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PHILIP MILLS JONES, M. D., Secretary and Editor

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IMPORTANT NOTICE!

All Scientific Papers submitted for Publication must be Typewritten.
Notify the office promptly of any change of address, in order that mailing list and addresses in the Register may be corrected.

VOL. IV

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No. 4

NOTICE.

SPECIAL RATES TO THE A. M. A. MEETING.

Those members desiring to avail themselves of the special rate of one fare for the round trip can purchase tickets at that rate from California points to New Haven, Conn., on May 25, 26 and 27. Upon arrival at New Haven, the ticket should be deposited with the proper agent. You can then buy a local ticket from New Haven to Boston. You may travel around as you please, but your return trip must begin at New Haven not later than August 31st.

Those who cannot avail themselves of this rate, can purchase a regular 9-months' tourist ticket, which will be sold at the rate of 2 cents per mile, or about $1\frac{1}{3}$ fare for the round trip.

EDITORIAL NOTES.

It is certainly encouraging to note the rapidity with which many of the county societies are taking hold of the idea of more frequent meetings and more systematic scientific work. Eight or ten are now meeting from two to four times a month and several others have the matter under consideration. Most of the economic problems which confront the profession and each individual member of it, are such as may not be solved by strife, but will yield to educational development, and the sooner we learn this the sooner will the solution of these problems be apparent to us. Elsewhere we print some courses of study outlined by a county society in a distant state and they should serve as a great help to others who are working

on the same general scheme. If isolation and ignorance breed strife and uncomfortable relations with others, then let us do away with the isolation by getting together, and with ignorance by careful, systematic study in the county society. This is the ideal place for such work, and there can be little doubt of the final outcome if this course is persistently followed.

That the mind of the physician is without commercial bent, is so well known as scarcely to require restatement; in the words of the "sure thing" operator, doctors and preachers are "good things." As a result of this unfortunate lack of business ability, physicians always have been and doubtless always will be, imposed upon by those gentry for whom "commercialism" is the first and the last word, and who know not the meaning of "professionalism." But every physician may take pride to himself in that, as the insurance examinations have shown, while thievery, bribery, corruption, stealing wholesale and retail have been going on for years in almost every department of the great life insurance companies except the medical, the medical examiners have gone about their work, honestly, conscientiously, faithfully, and no word of scandal has touched the name of a physician connected with an insurance company. Bear that fact in mind and then remember the disclosures of the investigating committee; remember the millions on millions of dollars shown to have been stolen from the policy holders by the McCalls, the McCurdys, the Hamiltons, the Alexanders, the Hydes, the Perkinses, the Depews and the horde of lesser thieves who were permitted, for years, to steal the policy holders' money. Remember, too, that there is every reason to believe that what has been told is only a fraction of the truth that might and should be told, and that the actual stealings and perversions of funds are probably many times the amount disclosed.

The disclosures of such enormous graft and such unblushing robbery have naturally produced a certain feeling of distrust in the public mind, and the "big three" insurance companies find that new business is hard to get—that "suckers" are scarcer than they were—that it is not so easy to get hold of the policy holders' money to steal as it was. Retrenchment is necessary; therefore they must retrench. How do they go about it. Do they cut down some of the enormous salaries? Do they trim the whole line of excessive "home office" salaries, commissions, expensive methods of getting business, etc.? Do they trim the agents' large commissions? One would naturally suppose that some of these things they would do, but we have not heard of any such. No; they ask the physicians of the country to put their hands into their own scantily filled purses and pay the deficit. They retain the fat

officials and fatter salaries, but they ask you to pay out of your mite, the losses caused by their past official stealings. Again it is the doctor who pays—through the nose. The doctor is glad to get what is given him; he is a humble beast and an uncommercial; he will swallow almost anything that he is told, if told in a convincing way; he is long suffering; he is used to working hard and often getting nothing for his services, therefore he will be glad to be assured of even a pittance. Therefore the Equitable and the Mutual recently decided to join the New York Life in the payment of cheap fees, and have notified all their examiners that the fee for examinations will hereafter be \$3.00 for all policies of \$3,000 or less. Is not this asking you to pay for the other fellow's defalcation? The Equitable says this action is taken "by order of the President." The "President" is one Paul Morton, formerly of the Santa Fe, where, in an official capacity, he entered into illegal contracts with other roads and later only escaped criminal prosecution through the "strenuous" clemency of Mr. Theodore Roosevelt! Mr. Morton is receiving \$60,000 (or is it \$80,000) a year salary; possibly he earns this huge amount by thinking up ways and means for skimping the physicians, or in shaving the policy holders in ways that are not within the reach of the law; he certainly cannot be worth that amount unless it is for some such reason. Are you going to quietly submit to this dictation by the "honorable" (Heaven save the mark!) president of the Equitable, the one-time dishonest railroad official and whitewashed ex-cabinet member? Refuse to do any examining for any company that does not pay \$5.00 for your work. Stick to it; be honest about it. And don't be sympathetic if the agent whines that he will have to pay the extra \$2.00 out of his own pocket; he is making many times the amount out of each risk that you are getting and he can mighty well afford to pay the extra \$2.00, if he has to! As a matter of fact, he will not have to, for the companies will come to time if you stick to your determination and let them go hang.

On December 7th, a letter was sent to 27 members of the Proprietary Association of America whose business is actually or ostensibly with the medical profession, asking them to please explain what they meant by holding out one hand for our dollars and whacking us through the Press Committee of the P. A. of A., with the other. The result was interesting; three wrote, in more or less temperate vein, that they were "in" for business reasons and intended to retain their membership; four have not replied; twenty have notified us that they have resigned. Elsewhere we give a list of the 27 houses and their relation to the P. A. of A., so far as indicated by all advices received to date. A certain amount of self-respect was sacrificed in writing

to such houses as Chas. N. Crittenton Co.; Fellows Mfg. Co. (advertising in many "medical" journals that their preparation is a cure for consumption); Mellier Drug Co. (like peruna, this concern tried to reap a golden harvest from the yellow fever epidemic and advertised, in reading notices, that their nostrum was a cure for yellow fever); Micajah & Co.; Katharmon Chem. Co. (make a cod liver oil preparation not containing any oil!). Look over the list.

Other things being equal, it is no less than right that we should lend the weight of our influence and give our patronage to those manufacturers who indicate a desire and an intention to help us in the present fight against fraud, secrecy and graft in the nostrum business. Is it not so? Then just stop and think when you need plasters, etc., that Seabury & Johnson are members of the Proprietary Association of America (the representative organization of the "Great American Fraud") and Johnson & Johnson are not. These two houses make practically identical lines of goods; why not give the preference to the house that is with us as against the house that contributes to the support of an organization representing so many frauds? Why not remember to ask for and buy Johnson & Johnson's goods? You will be doing the right thing and helping in the fight.

A bill to improve the condition of the Medical Corps of the United States Army has been introduced into Congress. It is a very good bill and has the approval of the Secretary of War and the President. It does away with contract surgeons and increases the regular force to a number almost sufficient to meet the requirements of the service. Write to your representative and urge the passage of the bill. Also write to Mr. Julius Kahn, who is a member of the committee on Military Affairs.

There are some bills which we may safely assume will be introduced into the next legislature, and we might as well think them over and begin to prepare for them. Without doubt one of them will be a bill requiring the full formula to be published upon the label and on the outside wrapping of all "proprietary" or "patent medicines." A bill of this sort has been introduced in the legislature of every state meeting this winter, and we may profit by the experiences of the bills in these states. Opposing the passage of such a bill we find, first, practically all the newspapers, on account of the "red clause" (this we republish for your information); second, the Proprietary Association of America; third, the whisky trust and wholesale whisky dealers, for many large manufacturers of whisky are

PROPRIETARY ASSOCIATION.

THE NEXT LEGISLATURE.

financially interested in some of the biggest selling "patent medicines"; fourth, the druggists and their Association, the National Association of Retail Druggists, commonly known as the "N. A. R. D." In passing we may respectfully call the attention of the W. C. T. U., the Y. M. C. A., the Y. W. C. A., and the various woman's clubs in the state to these facts and suggest that they begin NOW to plan an active campaign in support of the bill and to counteract the vast influence of the disgraceful elements which will oppose it. And what shall we do? The opposing factor nearest to ourselves is the "N. A. R. D.," and its individual members, the retail druggists. In other states they have shown that their desire to participate in criminal fraud is greater than their sense of professionalism, common honesty or self-respect; will they exhibit a similar attitude in California? Presumably, they will, if uninfluenced. It would therefore seem to be a paramount duty, and one of urgency, that we at once arrange for conferences with the druggists throughout the state—each county taking care of its own territory—and endeavor to come to an understanding on this matter. If an amicable understanding can be reached, so much the better, for fights are unpleasant, to say the least. It would be a comparatively easy matter for the physicians of the state to make themselves absolutely independent of the pharmacists, for it does not require a great deal of capital to equip a purely prescription drug store, and there is hardly a community in the state in which the physicians could not get together, subscribe the necessary capital and operate a co-operative drug store. Whether or not the local members of the N. A. R. D. will have sufficient influence with their organization to induce it to keep "hands off," is a question, for it has been many times intimated that the controlling element in the N. A. R. D. entertains the friendliest of relations with some of the biggest and worst of the fraudulent nostrums. Indeed its publication has several times since *Collier's* exposure, endeavored to bolster up the peruna fraud.

Indeed, it is quite possible that this same N. A. R. D. may do again what it did at the last legislature, and introduce, as a retaliatory measure, a bill emasculating our present law regulating the practice of medicine. It may seem almost incredible that an organization of druggists would be so gratuitously insulting, but the fact is one of record and was even bragged about in their official publication. The easiest way of protecting the people of the state against such outrages is to make sure of the attitude of your prospective representatives before they are nominated, if possible, and certainly before they are elected. A question of political party should have no weight with you as against the protection and safety of the people, who are your professional charge. That they do not know

enough to protect themselves and hence take but little interest in these matters, only makes it the more your duty to protect them from their own ignorance. For these and many other reasons, it should be your duty to take an interest in the political situation in your county and to make sure that every effort is made to send to the legislature men who understand the importance to public health and to the safety of the people, of properly safeguarding them from quacks and ignorant pretenders. They should be educated, too, on the more important facts regarding the "Great American Fraud"—the "patent medicine"—and the "red clause" control of the press. Fortunately, there are a number of country papers in this state that are free from the "patent medicine" yoke. We have noted *The Californian* (Eureka); the *Tulare County Times*, the *Fresno Daily Republican*, the *Ventura Free Press* and the *Pasadena Daily News*. Possibly there are others that have not come to our attention. It may seem a long time from now to next January, but the fight will be on your hands before you know it.

Where is the freedom of the press? Practically every newspaper in this country has been bought by the alcoholic nostrum manufacturers and has signed advertising contracts with them which contain the following clauses:

1st. It is agreed in case any law or laws are enacted, either State or National, harmful to the interests of the (Nostrum Manufacturing Co.), that this contract may be cancelled by them from date of such enactment, and the insertions paid for pro rata with the contract price.

2d. It is agreed that the (Nostrum Manufacturing Co.) may cancel this contract pro rata in case advertisements are published in this paper in which their products are offered, with a view to substitution or other harmful motive; also, in case any matter otherwise detrimental to the (Nostrum Manufacturing Co.'s) interests is permitted to appear in the reading columns or elsewhere in this paper.

(See *Collier's Weekly*, Nov. 4, 1905.)

The "Pure-Food Bill," the eighteen-year-old joke of the "Criminal Senate," has at last passed that august assemblage of official grafters and trust representatives! At the time of writing it is impossible to say whether the bill was emasculated before passage or not, but rumors are that it got through in fair shape. The fight will now be in the House and each and every one of us should write to his representative and demand that this effort to compel the substitution of simple honesty for murderous greed, be adopted.

There are at least as many fraudulent nostrums "worked" upon the medical profession alone as there are of the sort that appeal directly to the laity. From time to time we shall endeavor to follow the work of the A. M. A. and comment on these things. In the meantime, we would suggest that you ask every detail man who succeeds in getting to you and then contributes to

ATTACK OUR LAW.

FRAUDS IN MEDICINES.

your education, whether his preparation has been approved by the Council on Pharmacy and Chemistry of the A. M. A., and if so, just ask to see some documentary evidence of that fact; lying is easy and cheap. For instance, the Dios Chemical Co., advertises (or did) that its nostrums have been approved by the Council on Pharmacy and Chemistry—or implies as much. As a matter of fact, they have *not* been so approved, and doubtless would not be “in a thousand years!”

Apropos of the foregoing, we cannot resist a few words of comment anent a concern quite recently “sprung” upon us. Detail

A TYPICAL men have been visiting various
EXAMPLE. parts of the state leaving with physicians a beautifully printed pamphlet, entitled, in letters of gold, “The Balance Wheel of Life Metabolism.” If we dip into this scientific monograph—we should be grateful to the philanthropic “manufacturers,” the American Apothecaries Co., for placing so many pearls of wisdom in our hands without price—we will soon realize what fools we have been all the years of our life. We learn that “Elimination is aided by ‘salvitæ’”; that “Salvitæ dissolves tenacious mucoid secretions which often adhere to the alimentary canal”; that “It meets the pressing need of the majority of patients who consult a physician at his office.” Just think of that. All that such a majority of your patients need, is one remedy—“salvitæ”! And all these years you have been ignorant of how to really care for your patients! Studying this valuable treatise more carefully, we learn that “salvitæ” is specially suited to the “uric acid diathesis”: and also “specially indicated in cases of constipation with debility”; that it is a “genuine tonic laxative”; that it relieves or cures—generally cures—myalgia, neuralgia, constipation, Bright’s disease. “It invigorates the cells it cleanses;” “it preserves the life of cells.” “Salvitæ prevents premature fossilization of the individual,” for which the Lord be praised! Here have we been living a life of fear, dreading our approaching fossilization and not knowing that the philosopher’s stone had been found! What is this wonderful life saver and anti-fossilization agent, “salvitæ”? Merely a shot-gun effervescent saline cathartic!

“OUR CENSORIOUS CONTEMPORARIES.”

Under this alliterative title our esteemed contemporary, the *New York Medical Journal* (incorporating several other once decent medical publications, now alas! all managed by the same advertising agency) chooses to class us together with the *Journal of the American Medical Association*, the *CALIFORNIA STATE JOURNAL OF MEDICINE*, the *Pennsylvania Medical Journal*, and the *Maryland Medical Journal*. At any rate we are not ashamed of being in such company. Had we been classe^d with some other publications, that could be mentioned, we should not have been especially thankful. As to the imputation of “censor-

iousness,” we are inclined to be thankful for that too. Certainly, if our esteemed contemporary is so anxious to be advertised that he is thankful for being held up to the scorn of good men for his attitude in regard to the advertisement of nostrums, we might be thankful to be advertised as opposed to such a course. Tillotson said that: “Censoriousness and sinister interpretation of things, * * * render the conversation of men grievous and uneasy.” It seems that we have helped to render our esteemed contemporary quite uneasy. Albeit very thankful. His peculiar attitude reminds us of an old story of a hunting party who had passed a rule that the first man who was “censorious” with regard to the cooking would have to do the cooking himself. The cook for his part was “tired of his job,” and, as no one was willing to relieve him, began putting on the table the most unsavory mixtures; which, however, were received with unfailing commendation. At last he skilfully abstracted the center of the yolk of an egg and supplied its place with red pepper. The egg, of course, appeared as though nothing had happened to it. When it was bitten into, however, the biter jumped up into the air with a loud exclamation, that we need not quote verbatim, adding, nevertheless, as soon as he could recover his breath, “But I like it, I like it very much.”

So our contemporary “likes” our gentle criticisms and as he watches his advertising pages grow, makes the condemnatory remark about the profession, at least about that portion of it that is disposed to be honest and decent, that the late Mr. Vanderbilt once made about the public.

He reminds us of a juggler who is trying to keep five or six balls in the air at once, while he balances a sword on the end of his nose and sings Annie Laurie. He says himself in an editorial, under the title, “Mysticism in Medical Practice,” immediately preceding the one which has called forth these remarks, “There are patients who will not endure verbal jugglery on the part of a physician,” from which it is plain that he believes that the best of the laity have both more sense and more honesty than the profession. While he assumes to be the moral, intellectual and professional guide, philosopher and friend of all doctors whatsoever, his hands are red with the blood of decent medical journalism, which he is doing his best to murder. In an editorial in his issue of January 27, 1906, he inquires whether the doctor is an “easy mark” and states that “business men commonly regard the doctor as little more than an amiable fool where the investment of money is concerned.” Is not subscription to a medical journal an investment of money?

Could it be possible that the advertising agency that controls our esteemed contemporary is composed of business men?

The doctor may be an “amiable fool,” decency in medical journalism may be dead and calling nostrums, quacks and fakirs by their right names may be “censorious.” We believe, however, that there is something to be gained beside the approval of our own consciences by standing up for decency and common sense in the conduct of medical journals. If our neighbor really is thankful for our criticisms of his methods we will take care that he has much to be thankful for.—*Journal of the Med. Soc. of New Jersey.*

PROPOSED AMENDMENT TO CONSTITUTION.

Second Publication.

To amend Article X by adding after the second sentence the following:

The fiscal year of the Society shall be from January 1st to December 31st. The number of members in good standing in each component society on the first day of January of each year shall be taken as the basis for the assessment for that fiscal year, as fixed by the House of Delegates.

NOTICE.

The next Annual Meeting of the State Society will be held in San Francisco, the entire week, beginning Tuesday morning, April 17, 1906. The Rocky Mountain Interstate Society, the Pacific Branch of the Urological Society, and of the Ophthalmological and Oto-Laryngological Society will combine with the general and section meetings of the State Society. The scope and interest of our meetings will be thereby, very much enhanced.

The Committee on Scientific Work would particularly draw attention to the series of Clinics which have been arranged for the mornings of Friday, April 20th, and Saturday April 21st, at the various hospitals, which includes: Syphilis in all its manifestations, Tropical Diseases, Medical Cases of interest, general Operative Surgery, Genito-Urinary Surgery (Cystoscopy Ureteral Catheterization, etc.,) Eye, Ear, Nose and Throat Clinics. An abundance of rare and interesting material has been collected at considerable effort, and we would especially urge members to arrange to continue their stay over the morning of Saturday, April 21st.

The Committee would further announce that the following time limit has been placed on all contributions: Orations, thirty minutes, Scientific Papers, fifteen minutes, Discussion, five minutes. A bell will be rung in each case, one minute before the time expires.

Members finding subjects of interest in the papers enumerated below, will please send their names and choice of subjects to the Chairman of the Committee, that they may be called upon to enter into the discussions.

Committee on Scientific Work—Harold Brunn, M. D., chairman, 1312 Van Ness Avenue, San Francisco; C. M. Cooper, M. D., Philip King Brown, M. D., Philip Mills Jones, M. D., W. Francis B. Wakefield, M. D.

N.B.—The titles of many papers from the Rocky Mountain Interstate Society have not been received. The order of papers and time of presentation in the following program is therefore entirely provisional.

RAILROAD RATES.

The following arrangements have been made in regard to railroad rates for the April meeting:

A round-trip rate of one fare and a third on the receipt certificate plan; going tickets on sale ten days prior to the opening date of the meeting. Be sure and take a receipt-certificate when you buy your ticket to San Francisco. If you buy the lowest fare first-class limited through trip ticket, no stop over will be allowed; no stop over will be allowed in any event on the return trip. If you wish to stop over, buy an unlimited going ticket, which will cost a little bit more than the strictly limited ticket. The receipt certificate must be signed by the Secretary in order that you may secure the one-third return fare. Returning tickets may be purchased on or before Tuesday, April 24th.

PROVISIONAL PROGRAM.

Tuesday Morning, April 17th.

General Session, 10 A. M.

- (1). Address of Welcome; Dr. Wallace I. Terry, Pres. San Francisco Co. Med. Soc. (2). Address of the President; R. F. Rooney. (3). Report of the Committee on Tuberculosis; F. M. Pottenger. (4). Remarks from Committee on Medical Legislation and Education. (5). Remarks from Members of the Board of Examiners.

Tuesday Afternoon, April 17th.

Section Meetings.—2 P. M.—Medicine, Pediatrics and Obstetrics. Surgery and Gynecology. Urology, Syphilis and Skin Diseases. Eye, Ear, Nose and Throat.

Medicine, Pediatrics and Obstetrics, 2 P. M.

- (1). What is Rheumatism; Woods Hutchinson. (2). Effects of Saline Mineral Waters on Diseases of Metabolism and Nutrition; L. D. Meade. (3). Diet and Hydrotherapy in the Treatment of Rheumatic and Gouty Conditions; Robert Crees.

Discussion opened on three above papers; A. J. Sanderson.

- (4). Clinical Estimation of the Viscosity of the Blood; George E. Ebright.

Tuesday Afternoon, April 17th, 2 P. M.

Surgery and Gynecology.

- (1). Total Gastrectomy, with Report of a Case; Wallace I. Terry. (2). General Enteroptosis; J. Henry Barbat. (3). Liver Infection from Appendicitis; W. S. Thorne. (4). Early Diagnosis of Extra-Uterine Pregnancy; D. A. Stapler. (5). The Present Status of the Osmic Acid Treatment of Neuralgia; Thos. McCleave.

Tuesday Afternoon, April 17th, 2 P. M.

Joint meeting of the Pacific Coast Urological Association with the Genito-Urinary, Syphilis and Skin Section of the State Society.

- (1). "New Aphrodisiacs"; Dr. V. G. Veckl, San Francisco. (2). Further Report upon the Surgery of the Prostate Gland for Prostatic Obstruction in the Old, based upon Personal Observation in 140 cases of Prostatectomy; Granville MacGowan, Los Angeles. (3). Case of Lichen Planes involving the Bladder; George S. Whiteside, Portland. (4). Latest

Statistics in Perineal Prostatectomy; George Goodfellow, San Francisco. (5). Indications and Contra-Indications for Lavage of the Pelvis of the Kidney; Dr. M. Krotoszyner, San Francisco. (6). Tumors of the Bladder; A. B. Grosse, San Francisco.

Tuesday Afternoon, April 17th, 2 P. M.

Joint session of the Eye, Ear, Nose and Throat Section with the Pacific Coast Ophthalmological and Oto-Laryngological Society.

- (1). Eleven Cases of Sympathectomy for Glaucoma; Henry La Motte, Salt Lake City. (2). Student's Eyes; W. F. Snow, Stanford University. (3). An Original Method of Making Tropical Applications to the Mucous Membrane of the Naso-pharynx by Means of the Tongue; Hamilton Stillson, Seattle, Wash. (4). Report of a Case of Double Spontaneous Senile Cataract, with Posterior Displacement of Both Lenses; P. A. Jordan, San Jose, California. (5). Xanthelasma Palpebrarum; Thos. J. McCoy and A. C. Rogers, Los Angeles, Cal.

Wednesday Morning, April 18th, 9 A. M.

Symposium on "Anesthesia."

- (1). Preparation of Patient—Method of Administration and After Treatment in Normal Cases; Dr. Mary Botsford. (2). Complications (early and late) of Anesthesia—Recognition, Prevention and Treatment; Dr. Frank Bullard. (3). Spinal Anesthesia; Dr. A. W. Morton. (4). A Plea for the More General Use of Local Anesthesia; Dr. T. C. Edwards. (5). Scopalmine-Morphine Anesthesia; Dr. W. Winterberg. (6). Choice of Anesthetics; Dr. Henry L. Parrish.

Wednesday Afternoon, April 18th, 2 P. M.

Medicine, Pediatrics and Obstetrics.

- (1). Differential Diagnosis between true Sciatica and Diseases of the Urethra and Adnexa; G. S. Peterkin, Seattle, Wash. (2). An Instance of willful Deception in a case of Hysteria; E. D. Twichell, Sacramento. (3). Some unusual cases of Sepsis; W. W. Roblee, Riverside. (4). Some observations on the treatment of Diphtheria, based on work in the Contagious Wards of the San Francisco County Hospital; Langley Porter and Henry H. Lissner, San Francisco.

Wednesday Afternoon, April 18th, 2 P. M.

Section in Surgery and Gynecology.

- (1). Hernia of the Bladder through the Femoral Ring; Chas. Levison. (2). Spasmodic Torticollis; P. C. H. Pahl. (3). Considerations relating to the Ulna in Colles Fracture (Illustrated); H. M. Sherman. (4). Bennett's Fracture; Raymond Russ. (5). Static Deformities of the foot, with their Clinical Significance; Saxton Pope.

Wednesday Afternoon, April 18th, 2 P. M.

Joint Meeting of the Pacific Coast Urological Association with the Genito-Urinary, Syphilis and Skin Section of the State Society.

- (1). A combination of Syphilis and Epithelioma of the Tongue; D. W. Montgomery and H. M. Sherman. (2). Aetiology and Recent Experimental Work in Syphilis; Albert M. Grosse. (3). Alopecia Areata; Alexander Garceau.

Wednesday Afternoon, April 18th, 2 P. M.

Joint Session of the Eye, Ear, Nose and Throat Section with the Pacific Coast Ophthalmological and Oto-Laryngological Society.

- (1). The Diagnosis of Syphilis of the Throat objectively; H. H. Look. (2). Subhyaloid Hemorrhage; C. S. G. Nagel. (3). Mastoiditis and Sinus Thrombosis; George H. Powers. (4). Remarks on Radical Faucal Tonsillectomy; Henry Wagner. (5). General Diseases as a cause of Diseases of the Eye; M. W. Ward.

Thursday, April 19th, A. M.

Symposium—"Stomach Conditions."

- (1). Some Factors that influence the Secretion and Motility of the normal Stomach; Dr. A. W. Hewlitt. (2). Diagnosis of Diseases of the Stomach; Dr. L. G. Visscher. (3). Indications for Surgical interference in Stomach Diseases from the Physician's standpoint; Dr. George L. Cole. (4). Indications for Surgical interference in Stomach Diseases from the Surgeon's standpoint; Dr. DeBarth Shorb.

Thursday Afternoon, April 19th, 2 P. M.

Medicine, Pediatrics and Obstetrics.

- (1). Acute Suppurative Otitis media in childhood; Sanford Blum. (2). Report of 25 cases of Tuberculosis, treated with Intravenous Injections of Koch's Tuberculin; M. Rothschild. (3). Primary cause of Repair of Laceration of the Cervix; Adelaide Brown. (4). Statistics in some cases of Childbirth treated on the Dispensary Plan at the San Francisco Maternity; A. B. Spalding.

Thursday Afternoon, April 19th, 2 P. M.

Surgery and Gynecology.

- (1). Conservative treatment of Hip-Joint Diseases; S. J. Hunkin. (2). An Analysis of the Different Methods of Replacing the Congenitally Dislocated Femoral Head; J. T. Watkins. (3). Coxa Vara; Ethan H. Smith. (4). A new method for amputating the Thumb; Julius Rosenstirn. (5). A Case of Primary Tuberculosis of the Kidney with Nephrectomy; John C. Spencer.

Thursday Afternoon, April 19th, 2 P. M.

Joint Session of the Eye, Ear, Nose and Throat Section with the Pacific Coast Ophthalmological and Oto-Laryngological Society.

- (1). Infectious Sinus Thrombosis without Symptoms with report of a case; C. F. Welty. (2). A new Giant Eye-Magnet with Demonstrations; A. Barkan. (3). The Use of the Stenopeic Slit in Refraction; W. Scott Franklin. (4). Subnormal Accommodation; F. B. Eaton.

Thursday Evening, April 19th, 8 P. M.

Symposium—"Borderline Conditions of Lung and Pleura."

- (1). Tumors of Lung and Pleura; Dr. Wm. Ophuls. (2). Diagnosis of Lung Conditions requiring surgical interference; Dr. George H. Evans. (3). Pleural Effusions; Dr. Wm. Watt Kerr. (4). Problems of Lung Surgery; Dr. Dudley Tait. (5) Diagnostic value of X-Ray in Chest Conditions. (Stereopticon Demonstration); Dr. W. Lehmann.

Friday Afternoon, April 20th, 2 P. M.

Joint General Session with the Rocky Mountain Interstate Society.

- (1). Address by President of Rocky Mountain Interstate Society; Dr. Edward Jackson, Denver, Colo. (2). The Pioneer Physicians of California from the earliest Spanish times to the gold days; Irwin N. Frasse, San Jose. (3). Medical Defense; W. S. Fowler, Bakersfield. (4). Compulsory Registration and Fumigation in the Prevention of Tuberculosis; George H. Kress, Los Angeles. (5). The Social Evil, its cost and control; George H. Alkin, Fresno.

Friday Morning, April 20th.

Surgical Clinics, 9 A. M.

General Operative Surgical Clinics. Genito Urinary Clinics. Orthopedic Clinics. Eye, Ear, Nose and Throat Clinics.

At the Following Hospitals.

City and County Hospital. Lane Hospital. German Hospital. St. Francis Hospital. Children's Hospital. Southern Pacific Hospital. United States General Hospital, Presidio.

Saturday Morning, April 21st.

Medical Clinics, 9 A. M. City and County Hospital.

- (1). Syphilis in all its manifestations. (2). Tropical Diseases with microscopical exhibit of Specimens. (3). Rare and Interesting Medical Cases.

THE MOTOR COMPLICATIONS OF HERPES ZOSTER.

By ALBION WALTER HEWLETT, M. D., San Francisco.

THE eruption of herpes zoster, which consists of vesicles upon inflamed bases, is characterized mainly by its limitation to the portion of skin that is supplied by the affected spinal ganglia. Head¹ distinguishes two forms of zoster. The first is merely a symptom of some more general nervous disease and it is called, therefore, symptomatic zoster. The second is a disease *sui generis* and has been termed acute specific zoster. This latter is characterized by the presence of fever, together with the general symptoms of an acute infection, by a self-limited course, by the tendency to occur in epidemics, and finally by the fact that one attack confers upon the patient a relative immunity to future attacks. These data serve to place this form of zoster among the acute infectious diseases. Anatomically it is characterized by an acute hemorrhagic inflammation of the posterior, sensory, nerve-root ganglia.

As might be expected, the motor lesions associated with symptomatic zoster are numerous and varied. For example, in myelitis the skin supplied from the upper level of the lesion may be the seat of a zoster. In spinal caries zoster may occur at the level of the gibbus; zoster is not an infrequent symptom of tabes dorsalis and of dementia paralytica²; it may accompany hemiplegia³; and finally it may follow tumors or traumata of the central nervous system. It is sometimes very difficult to determine whether the primary lesion has actually caused the zoster or whether it has merely opened the portals for an attack of the acute specific form of the disease. In some cases, however, the two forms of the disease are easily distinguishable. For example, when the zoster recurs repeatedly, or when it exhibits a bilateral distribution, we may exclude with some probability the specific form of the disease; for only very rarely is this either bilateral or recurrent. As an example of the association of paralysis with symptomatic zoster, I may cite a case that came under my observation at the New York Hospital.

Case I. A young man, on diving into shallow water, struck his head with considerable force. He stated that he did not become unconscious immediately but that he was simply unable to move either his arms or his legs. In this condition he sank, became unconscious, and was only rescued after being in the water for about five minutes. When he regained consciousness about twenty minutes later, he could move his legs but his arms were completely paralyzed. After 30 minutes more the power began to return to his arms. The next day, when he was admitted to the hospital, his arms were still very weak and were not under complete voluntary control. On each arm, between the elbow and the shoulder, was an area over which the sensations of pain and temperature were lost while the tactile sensation was unimpaired. Three days after the injury, a bilateral cervical zoster appeared, involving the skin distribution of the third and fourth cervical segments. This healed rapidly, the patient regained control over his arms, the sensory disturbances gradually cleared up, and he left the hospital ten days later practically well. The nature of the accident, the sudden onset of the paralysis, the dissociated loss of cutaneous sensation, the favorable outcome, all favor the diagnosis of a hemorrhage into the cervical cord. The zoster was of the symptomatic type, for it followed the injury directly and it was bilateral.

We now turn to the consideration of the motor disturbances that may be associated with the specific form of zoster. *A priori* it would seem very probable that an inflammation of the sensory ganglion might spread from there to the nerve itself and that the involvement of the motor fibers might lead to a paralysis of the muscles supplied by the affected nerve. As a matter of fact, however, very few cases have been reported which would fall in this category. Yet we must remember the great frequency with which zoster affects the trunk, about 76 per cent of Head's cases¹. The paralysis of a single motor nerve in this region is not easily recognized and quite possibly it occurs far more frequently than a study of the litera-

ture would lead us to believe. I have been able to find only one case reported in which the muscles of the trunk were paralyzed after a zoster. This patient¹² was a woman, sixty years old, in whom a lumbar zoster was followed by a paralysis of the abdominal muscles on the same side.

Next in frequency to the body zoster come those of the face and neck, which will be discussed later. Finally, rarest of all, come the zoster that affect the extremities. If we take into account the rarity of these, it would seem that motor complications are here relatively common. I have references to some eleven cases which belong with more or less certainty to this class^{4, 5, 6, 7, 8, 9, 10, 11}. For example, Walter's¹¹ patient, a man fifty years old, was attacked with zoster of the right arm and eight days later with a paralysis that apparently involved the circumflex and musculo-cutaneous nerves. Hardy's⁸ first patient had zoster along the course of the sciatic nerve which lasted some twenty days with remissions and which was followed a month later by a complete atrophic paralysis of the muscles of the calves and of the outside of the leg. Joffrey's⁷ Case I showed an atrophic paralysis of the small muscles of the hands subsequent to a zoster of the shoulder. Other cases placed in this class are of a more doubtful nature. Thus Ebstein¹¹ questions the paralysis in the cases reported by Broadbent⁴ and Handfield Jones⁵; Schwimmer's⁹ patient developed his symptoms after an injury to the shoulder and the zoster may have been of the symptomatic type; while the abstracts of Magnus⁶ and Härtmann's¹⁰ cases that are available to me are not sufficiently complete to allow me to classify them accurately.

Herpes about the face and neck is more frequently associated with paralysis than is herpes of any other part of the body. These paralyses are of especial interest for the reason that the motor nerves affected do not coincide with the sensory nerves. These paralyses may be divided into (1) ocular paralyses subsequent to herpes zoster ophthalmicus, (2) facial paralysis following herpes of some division of the fifth nerve, (3) facial paralysis preceding herpes zoster of the fifth nerve, and (4) facial paralysis as a sequel to zoster of the neck.

The first of these, the ocular paralyses, have been thoroughly discussed by the oculists^{13, 14} and it is therefore unnecessary to attempt an exhaustive discussion of this subject. According to Wecker (cit. in¹⁴), ocular paralyses of some sort complicate about seven per cent of all cases of zoster ophthalmicus. The most frequent of these paralyses are those affecting the third cranial or oculomotor nerve. This nerve may be paralyzed in its entirety or in any of its component parts. Thus the internal ocular muscles may be paralyzed alone; or the external muscles supplied by this nerve may be paralyzed, or the levator palpebræ may be alone affected, etc. Paralysis of the sixth cranial nerve, the abducens, is more uncommon; while rarest of all the ocular paralyses are those that affect the fourth or trochlear nerve.

The second of the above groups comprises those cases in which a facial paralysis follows a herpes zoster of some portion of the skin supplied by the fifth nerve. I have been able to collect twelve such cases from the literature. The general history of these is as follows: herpes zoster of some division of the fifth nerve, usually the first, followed within a few hours to a few weeks by a paralysis more or less complete of the seventh nerve on the same side of the face. In Murphy's¹⁵ case and in Caspar's¹⁶ case, the paralysis affected the facial nerve on the opposite side of the face. In Truffi's¹⁷ case the second and third divisions of the fifth nerve were affected, in Tay's¹⁸ case the first and second divisions. In Montgomery's¹⁹ case, the facial paralysis that followed an herpes ophthalmicus, involved only the uppermost fibers of the seventh nerve, i. e., those supplying the right frontalis muscle.

The third group comprises those cases in which the facial paralysis precedes the facial zoster instead of following it. Four such are on record.^{25 26 27 28} One of these²⁸, however, followed a severe injury to the skull, probably a fracture, and should therefore be classed rather with the symptomatic zoster. In Eichhorst's²⁵ case, the most typical one of this group, the herpes appeared four days after the facial paralysis and involved the lower half of the right ear, the external auditory canal, and the right side of the tongue and hard palate. The sense of taste and the movements of the uvula were not affected. In Tryde's Case III²⁷, the herpes did not appear until three months after the paralysis and it was limited to the distribution of the first division of the fifth nerve. In Remak's case²⁶, the herpes appeared only on the anterior two-thirds of the tongue on the affected side.

Finally we come to the most frequent form of facial paralysis associated with herpes zoster; viz., paralysis of the seventh nerve after a zoster of the cervical region on the same side. I have recently seen two such cases and as they are fairly typical of the group I shall first report these.

Case II. Mr. S., 65 years old, was referred to me by Dr. Geo. B. Somers. On March 24, 1905, the patient had suffered from slight pain in the left shoulder. On the 27th, the skin of the left side of the neck had burned uncomfortably and examination then showed it to be red, swollen, and of a boggy consistency. At the same time, the neighboring lymphatic glands became swollen and the patient had some fever. Two days later, on the 29th, vesicles appeared on the red spots and the neuralgic pains became more severe, extending to the top of the head, to the left ear, the left shoulder, etc. The skin over the affected area had now become hyperesthetic to the touch. On April 3d, about seven days after the appearance of the red spots, the patient noticed that his left eye did not close so well as his right, and on the 5th of April, two days later, this paralysis had become definite and had extended to the muscles of the mouth. The herpetic eruption healed with some scarring but most severe neuralgic pains continued to harass the patient. These extended over the left back of the head and the whole of the left side of the neck, and were so severe that the patient could not sleep.

Physical examination on April 14th showed a pale, nervous, and rather thin patient with a left-sided facial paralysis. The left forehead and left mouth were completely immobile but the left upper eyelid could be closed slightly. No loss of taste, hearing normal, palate symmetrical. Electrical examination: facial muscles will contract when the nerve is stimulated either by the galvanic or the faradic current, though the muscles about the mouth do not respond so readily as do those about the eye. All the muscles are irritable to direct stimulation either by the faradic or galvanic currents but those on the left side are more irritable to direct galvanic stimulation than are those on the right side of the face. The cathodal closing contraction is stronger than the anodal closing contraction. Scars of the previous herpetic eruption are plainly visible on the left side of the neck and these with the hyperesthesia of the skin correspond to the distribution of the second, third, and fourth cervical segments. Enlarged cervical glands can be felt above the left clavicle.

The facial paralysis improved gradually but even now, ten months later, it has not entirely disappeared. The neuralgic pains also persisted for a long time.

Case III. A. G., an Irish woman, 60 years old, was admitted to the medical service of Dr. J. O. Hirschfelder, at the City and County Hospital, in July, 1905. Family and past history negative. Uses alcohol and coffee moderately. About one week before admission patient noticed a painful reddened area over the left side of the neck, extending down to and over the clavicle. She attributes this to some kerosene that she had dropped into her ear about a week before for buzzing in the ear. Two days after the redness appeared on the neck the skin began to turn a darker color and to peel off. She does not recollect any vesicles on the neck, but is very uncertain about the details of her illness. On the third day after the onset of the rash patient found that the left corner of the mouth did not move properly, and that the left eye troubled her.

Physical examination on July 28th showed a well nourished but pale woman with negative physical findings except for her face and neck. The left side of the face is completely paralyzed, the forehead being smooth, the lower lid everted, the mouth motionless. Taste is completely lost over the anterior portion of the left side of the tongue. Hearing is equally poor in both ears. Ear drums negative. Palate at times appeared symmetrical, at other times the right side seemed higher than the left and the uvula seemed to be deflected to the right. The left side of the neck is covered with a series of reddish scars, to some of which crusts are still clinging. The skin over this area is intensely hyperesthetic; the least touch causing the patient pain. The distribution of this hyperesthesia (see

Fig. 1) corresponds to the distribution of the second, third and fourth cervical segments. Patient is troubled with severe neuralgic pains in the left neck, and at times she has parasthesias, such as the sensation of pins and needles. Electrical examination: All the muscles contract when the facial nerve is stimulated, either by the galvanic or by the faradic current. A much smaller current is necessary to cause a contraction when the left facial nerve is stimulated (0.3 milliamperes for the C. C. C.) than when the right facial nerve is stimulated (0.7 milliamperes for the C. C. C.). On direct stimulation of the muscle the cathodal closing contraction is stronger than the anodal closing contraction. The contractions are much slower on the diseased than on the healthy side.

The facial paralysis gradually improved. On August 18th she could close the left eye voluntarily. On August 29th she wrinkled the forehead and closed the eye almost as well on diseased as on the healthy side; the muscles about the mouth could also be moved slightly, but taste was still defective. On October 17th taste had returned and the patient could move all her facial muscles; but those on the left side, especially about the mouth, were decidedly paretic and showed a tendency to contracture. When she was discharged, December 11th, she had improved somewhat more in the use of her face, but the paralysis was still noticeable. Throughout her stay in the hospital she was tortured with severe neuralgic pains about the left neck, and had a hyperesthesia of the skin in this region, so severe that she protected the affected skin even from the touch of her clothing. For her pains and hyperesthesia a great variety of remedies were tried, but none afforded so much relief as the freezing with ethyl chloride, that has been recommended by Morrow. The pains and the hyperesthesia were still troublesome when she left the hospital.



Illustration of case reported.

In addition to these two cases of facial paralysis following zoster of the neck, I have been able to find 23 similar ones in the literature. The condition therefore is not particularly rare. Head observed one such case in a series of 412 zoster cases of which about 40 were cervical zoster. Greenough²⁹ observed one such case among 255 zoster cases of all kinds, but he also observed one case not included in this series. Of the histories and abstracts at my disposal, twenty, including my own, are sufficiently full to permit tabulation as to age, sex, distribution, etc.

The results of this tabulation may be summed up as follows: The ages of the patients varied from 17 to 75 years, the average being 48 years. This is in marked contrast to the average of all zoster cases, for

the latter are most frequent among young individuals, Head stating that the maximum incidence in his cases lay between 12 and 13 years and that over 70 per cent were under 20 years. This further illustrates the fact that herpes zoster is a far more serious disease in elderly people, for not only are the neuralgias more severe but motor complications are more liable to occur. So far as sex is concerned there seemed to be a slight preponderance of the female sex. In nine patients the left side was said to be affected, in ten the right. The location of the zoster is variously described, but in the main it seems to have occupied very much the same position as it did in my cases. In several patients it appears to have involved the face as well. The paralysis appeared in from one to fourteen days after the zoster, the average being about six days. The extent of the paralysis varied greatly; from one in which only the upper facial muscles were paralysed and the lower only slightly paretic, to others in which all the muscles were paralysed with a complete reaction of degeneration and the uvula and taste were affected. The duration of the paralysis was equally variable; for in one patient it disappeared in four days while in others it had not disappeared after months.

The cause of the motor paralyses that may accompany herpes zoster is by no means clear. We have already mentioned the possibility that the inflammation might spread from the diseased ganglion to the main nerve trunk and there affect the motor fibers with a consequent paralysis of the muscles supplied by this nerve. Yet this explanation hardly holds for the cases where a cervical zoster is followed by a facial paralysis. Two main theories have been advanced to explain such cases. According to the first the disease is comparable to a multiple neuritis and the facial nerve falls a victim to the poison on account of some special susceptibility. If this theory were correct, we should expect the facial nerve on the opposite side from the zoster to be affected just as frequently as is that on the same side. Yet such is not the case; for in all of the cervical zoster cases here collected the paralysis and the zoster were on the same side of the body. This explanation therefore seems highly improbable. According to the second theory, the inflammation spreads from the cervical ganglia along the cervical nerves, then from their anastomoses on to the terminations of the seventh nerve, and finally it travels up the seventh nerve and paralyzes it. Cumbersome as this hypothesis is, it appears to be the most satisfactory that has been advanced thus far. One might consider, in addition, the possibility that the zoster of the neck caused a swelling of the tissues—e. g., glands, periosteum—about the ear, and that in this manner a pressure paralysis of the facial nerve resulted. Yet in some cases at least, the loss of taste locates the lesion within the petrous portion of the temporal bone; and, so far as I know, we possess no evidence that the cervical plexus supplies the structures within this bone.

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THE EDUCATIONAL TREATMENT OF THE NEURASTHENIC AND HYSTERICAL CONDITION.*

By JAMES T. FISHER, M. D., Los Angeles.

TO EDUCATE the neurasthenic out of his fears or strengthen the will of an hysterical woman requires for its successful outcome a deeper insight into and understanding of mankind than does that of almost any other bodily or mental disease. Hysteria and neurasthenia are not, as are many organic diseases, self limited, but grow little by little, taking upon themselves bigger proportions from their surroundings.

Dr. Weir-Mitchell a number of years ago made a marked advance in the treatment of these neuroses by his so-called "rest cure," requiring a combination of forced feeding, absolute rest, passive exercise and isolation. He assumed that the pathology of the disease was a faulty nutrition, and that by making "fat and blood," thus improving nutrition, the symptoms would disappear.

The rest cure is ordinarily considered a very simple method and a device very easily executed and regarded as a specific, as one would give mercury for syphilis. This is not altogether the case, and much disappointment and surprise has been experienced by its frequent failure to restore to health the neurasthenic.

This form of treatment, like other treatments, has its place, and in selected cases in the hands of the experienced has done a world of good and made both patient and doctor happy.

As to the assumed pathological principle "faulty nutrition," it is indeed a part, but only a part, and the cures effected by the rest treatment are due to other influences, largely moral and educational, rather than to the nutritive factor.

It is often the case that with gain in weight the symptoms fail to disappear, and with good nutrition marked neurasthenic symptoms are present. Increase in the amount of fat and blood does not necessarily cause the nervous system to react normally and remove the conditions of fatigue. Inanition may play its role, but other factors enter in.

On the other hand, no form of treatment which affords a prospect of anything like enduring results can afford to leave wholly out of sight an improvement of nutrition. We all know that people in good health are usually well nourished, and when they begin to break down they lose flesh. Conversely, that poorly fed and nourished people can not stand the wear and tear that the well nourished can. Imperfect nutrition tends to perpetuate the symptoms. When malnutrition is present fatigue is more easily induced, and in fatigue, symptoms are more easily excited and tend to persist.

Habit symptoms are less easily broken up, and a tendency to relapse is greater. The neurasthenic state is certainly one of fatigue, and is more easily induced when malnutrition exists.

More than the supposed scientific principles upon which any particular treatment is based are the practical results which are obtained by it. That the rest treatment has been successful in experienced hands, especially by its distinguished originator, must be accepted, irrespective of any contrary results that may have fallen to the lot of individuals. Nevertheless there are often certain drawbacks, and I may even say ill consequences of this method and certain difficulties in carrying it out.

It is obviously an expensive means of treatment. Many cases which are distinctly curable, and which later were cured, by other methods, have failed to be cured by the rest cure, though systematically employed. As I have said, while the treatment has been apparently successful in the hands of certain individuals, nevertheless it has been a failure in the

hands of a great many. It is not a treatment which is calculated to give equal results independent of the personal qualifications of the physician; this largely because its fundamental principle has been wrongly interpreted, and therefore the treatment itself has been too often improperly carried out. Furthermore, many patients far from being cured, are made distinctly worse, and become more confirmed invalids than ever.

The rest cure not only makes use of improved nutrition, but employs the most powerful of all therapeutic agents in neurasthenic and hysterical conditions, namely, every moral influence that can be brought to bear by means of change of surroundings, isolation, active physical manipulation of the body, and the personal influence of the physician. When this moral influence is lost sight of and reliance has been placed by the physician upon mere physical details, looking mainly to increase in nutrition for the therapeutic effect, the result is likely to be a failure. Under such circumstances I do not hesitate to say that the rest cure has done much harm, a result which, as I have said, has been due to a misunderstanding of the real principles involved.

As a method which I consider superior I would suggest, for lack of a better name, "educational treatment," combining with this mental therapeutics and physical hygiene.

For a successful issue of the treatment of these functional nervous diseases it has been found that isolation is a necessity, is in fact a *sine qua non*, and that at least in severe cases, without it, the rest cure has been a complete failure. It is a matter of common knowledge that while the influence of isolation is complex, its chief mode of action is mental. This is so patent and well recognized that I need not take further time to explain its mode of action. So here is introduced a mental factor in addition to the primitive idea of making fat and blood.

It must be apparent to any one familiar with isolation in nervous and mental diseases that the effect of the mental influence can be enormously augmented or impaired by the individuality and the attitude of the attending physician.

In regard to isolation a point to be determined in the treatment is how far isolation is necessary. Only in severe cases of hysteria do I think isolation is necessary.

Separation from previous surroundings and associations, and particularly not only from all members of the household, but from the house itself, is always beneficial, and a great help to the treatment. In fact, I believe this to be the strongest moral therapeutic agent and as potent as perhaps any factor in bringing about a cure. Where there are no serious difficulties in the way of obtaining a limited isolation of this kind I advise it as a great help, but I do not think that absolute isolation is necessary or desirable. On the contrary I would suggest a systematic development of new associations, encouragement of new thoughts, of new physical and mental habits, which are best brought about not by complete isolation, but by bringing the patient in actual contact with new surroundings.

The more hysterical the individual, the more marked the mental symptoms, the more emotional the character of the disability, the greater the necessity for separation and change of all external influences.

Our effort from first to last should be to lift our complaining patient up out of the quagmire of despair and dread and supplant hope and courage in his heart. The fact that a careful examination and a bitter pill effects a cure, mainly by its appeal to the mind, in no way detracts from them as sensible therapeutic measures. Why should we fail to use the one effective measure that secures success to our neighbors, the osteopath and the Christian scientist?

The mind of the patient requires far more treatment than his body or its functions.

* Read before the Los Angeles County Medical Society, January 5, 1906.

To inspire the utmost confidence and maintain complete authority is the plan which will best avail us in overcoming his symptoms. All his symptoms are no doubt lessened and occasionally overcome by the use of physical agencies, but they are more surely eradicated by the use of the proper kind of psychical and moral treatment.

With confidence the patient is amenable to suggestion. This psychical influence can be made most effective when used through the medium of physical measures, which experience has shown to be so serviceable in the treatment of neurasthenia.

The neurasthenic is in a psycho-physical state of increased suggestibility, and furnishes fruitful soil for all kinds of suggestion. Having obtained the hearty co-operation and confidence of the patient, we endeavor to improve the mental state by dislodging the fixed ideas regarding the incurability of the disease, the apprehension and fear, the subconscious memories and ideas producing hysterical symptoms.

One of the most common mental states is the belief on the part of the patient that doing things that bring on symptoms will do permanent harm. They are most apprehensive that the fatigue incident to a little work will do irreparable harm, and prevent recovery. Hence they do less and less till finally they become bed-ridden.

Mrs. B., seen with Dr. W. L. Brown, illustrates an extreme case of hysterical neurasthenia. She suffered from dyspepsia and an abdominal neurosis or paresthesia. Careful investigation showed the dyspepsia to be mostly false and to be really a hyperesthesia of the stomach of probably the same pathology as is the common photophobia of the eyes in neurasthenia. The abdominal neurosis was also found to be of a similar character. She had lain in bed for seven months, unable to get up or eat without distressing symptoms. We made her walk and eat and do the very things she thought would kill her, with the result that now the symptoms have disappeared. The key to the multitude of symptoms exhibited by this woman almost always can be found to be apprehension or auto-suggestion.

The next point in the instruction of the patient is the interpretation of his symptoms, the explanation of the meaning of his aches and pains, of his palpitation and clammy hands. An effort is made to instruct the patient in the nature of the disease and its varied symptoms. This can ordinarily be done with an intelligent patient and his co-operation be obtained. A further endeavor is made to counteract his many fears and fixed ideas by reasoning with him, trying to suppress many of his symptoms by various therapeutic agents, sometimes electricity or drugs to assist suggestion. Many of his symptoms are the result of a habit neurosis, due to association of ideas and actions. When fatigue is a false or habit fatigue, this should be explained. It may take a little time and some patience, but the result will repay the effort.

The patient should be taught to control and inhibit his emotional state, worry, anxiety, fear and anger.

Symptoms grow like nourished plants and should be suppressed as fast as they appear by some therapeutic measure, in order that faulty habits should not get full sway and dominate the nervous system.

For the suppression of symptoms I know of no better method than by direct suggestion. It is not necessary to resort to hypnotism, but sufficient influence can be obtained in the waking state with the aid of electricity in almost any form—either the static breeze or a faradic battery. At the time the electricity is applied the suggestion is given and with some considerable emphasis, and the patient instructed in the nature of the disease and what is expected. The physical effect of the electricity is not to be entirely overlooked in suppressing painful feelings and fatigue sensations.

We must not forget that suggestion is, or may be, a double edged weapon, and may be the means of

great good or be the cause of much unhappiness and misery. We may by some little word or act suggest to our patient that insomnia or discomfort may occur under certain conditions; that the disease is fatal, and thus set up a train of ideas and morbid thoughts which will be hard to overcome. In other words, it is quite possible to plant seeds that will result in artificial cultivation of symptoms.

We must educate our patient to do that which he thinks he can not do. Our attitude must be that of the trainer to the athlete. If he can not sit up without a throbbing head and heart palpitation, he must be made to do so. If he can not walk without fatigue, he must be taught to do so. If he can not eat without dyspeptic symptoms, the stomach must be taught to accommodate food without pain and belching gas. By all means do not restrict your patient because he can not do things without discomfort.

When no organic lesion exists, insist that he shall do certain things, and see that he does them.

Finally I would say that in the educational treatment of both neurasthenia and hysteria a systematic method of life should be insisted upon. That for every hour of the day some act or task be done to keep the mind of the patient busy, which acts as a strong moral and physical corrective.

In conclusion, allow me to recapitulate. The education of our patient consists in: First, the full explanation of the disease and the meaning and the significance of different symptoms. Second, the apprehension and fixed ideas counteracted by suggestion, and faulty habits corrected. Third, individual symptoms dissipated and relieved by some mechanical device—a bitter pill, electricity—all given with direct suggestion.

THE DEMONSTRATION OF DILATATIONS OF THE DESCENDING THORACIC AORTA.*

By CHARLES MINER COOPER, M. B.

THE descending thoracic aorta is the direct continuation of the aortic arch, and it traverses the posterior mediastinum. It begins at the lower border of the fourth dorsal vertebra and ends by becoming the abdominal aorta at the level of the twelfth dorsal vertebra. At its commencement it lies to the left of the middle line, but as it proceeds downward it inclines inward approaching a mesial position at its termination. Situated as it is within a bony cage and coming nowhere in contact with the ribs or sternum, it gives rise to no appreciable clinical signs. Inspection, palpation, percussion and auscultation, alike, fail to give any indication of its presence. It is thus easy to understand that lesions of this vessel are extremely difficult of diagnosis.

True chronic, apparently causeless, intercostal pain in an adult, who has wrought hard and had syphilis, should in the continuous absence of other nerve symptoms render the clinician suspicious of a commencing aneurism of this portion of the vessel.

Later pressure upon the left bronchus, the esophagus or the azygos veins may occasion symptoms which strengthen the suspicion of the presence of an aneurism, more especially if concomitant relative weakening of the crural pulses occurs.

Still later when the aneurism has so grown as to come in direct contact with the left ribs, as they arch back from the bodies of the vertebrae, the classical physical signs of aneurism are present and the recognition of the lesion becomes easy.

In what may be termed the pain stage the clinical diagnosis is problematical, in the pressure stage the diagnosis is at best clinically probable, in the third stage no reasonable doubt exists. Sometimes of course no definite stages occur and an evident aneurism of this vessel may be present in one who

*Read at the Academy of Medicine, San Francisco.

has apparently suffered from no symptoms referable to its formation and growth.

In some patients whom the writer has seen the aneurism appears to have pushed the heart forward, apparently fixing it. In such cases the superficial and deep cardiac dullness have corresponded. The anterior lung margins have moved little in respiration and the heart dullness has not changed on postural movements. In the first case, which I traced to post-mortem, I ascribed these physical signs to the huge heart that was present. But since then I have seen another patient in whom these signs are present, in whom no indication of pericardial or pleural adhesions exist and in whom careful clinical examination, which included an X-ray negative, shows a heart which is not much enlarged with a large aneurism lying posterior to it; perhaps this increase of the superficial cardiac dullness without a corresponding increase in the deep cardiac dullness, together with the constant absence of the postural heart swing may be of diagnostic service in patients with symptoms suggestive of the first or second stage of retro-cardiac aneurism.

In the CALIFORNIA STATE JOURNAL OF MEDICINE, June, 1905, I reported some instances of abdominal aneurism and briefly referred to one case of supradiaphragmatic aortic aneurism in which fluoroscopic examination revealed the semicircular pulsating mass the presence of which had not been previously suspected. We can thus in such cases readily control our clinical suspicions.

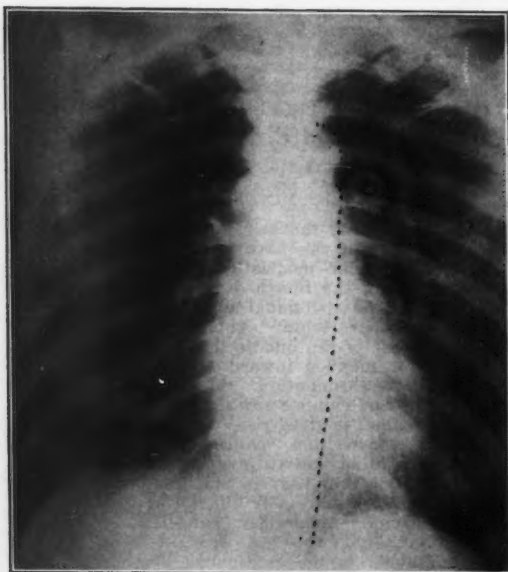


Fig. 1. The descending thoracic aorta is shown as a dotted line to the observer's left, at the root of the lung a small calcified area is visible lying amongst the tubercular infiltration.

I now wish to demonstrate radiograms on which can be plainly seen the shadow cast by the normal descending thoracic aorta in its entire course and also radiograms showing dilatation of this vessel.

Print No. 1 is of a patient seen in consultation with Dr. J. Wilson Shiels in whom a clinical diagnosis of peribronchial tuberculosis seemed justifiable. The photograph shows the presence of such infiltration, a part of which is calcified. But of more interest, in regard to the subject of this paper, is the fact that the shadow cast by the descending thoracic aorta is well shown. It begins on the left of the lower border of the fourth dorsal vertebra.

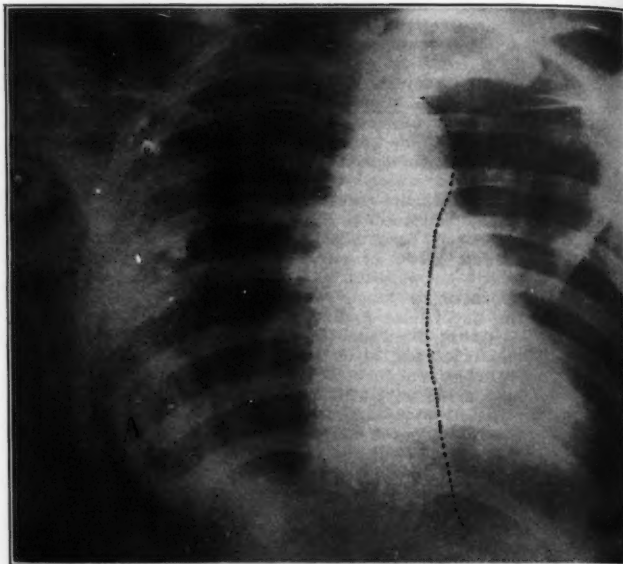


Fig. 2. (Kindness of Dr. Jellinek.) The concavity of the descending thoracic aorta has been dotted in. To the right A is the shadow cast by a pleural infusion.

The left margin of the shadow here projects three-quarters of an inch beyond the left margin of the shadow cast by the vertebral body. The right border of the aortic shadow is of course not visible, being obscured by the vertebral shadow. The left aortic border runs apparently straight along the sides of the fifth, sixth, seventh and eighth dorsal vertebrae, when it begins to approach the middle line so that opposite the twelfth dorsal vertebra its border lies only a quarter of an inch distant from the left border of the shadow cast by the body of that vertebra.

Print No. 2 shows a similar shadow in a lady who has marked lateral curvature. It will be noted that the left margin of the aorta casts a shadow corresponding in its curve to that cast by the rotated

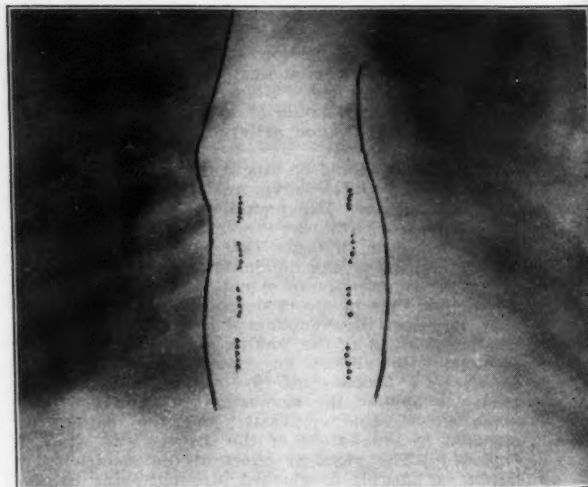


Fig. 3. Continuous black lines mark the borders of the vessel dilatation. The inner dotted lines represent the margins of the vertebrae between the rib attachments.

vertebral column, which of course agrees with the anatomical findings in such cases: the aorta being relatively fixed by the intercostal arteries.

Print No. 3 is interesting as it is a print of a patient who has hypertrophic arthritis of his lumbar spine, marked arteriosclerosis and has had double pleurisy; he further complained of pain along his dorsal spine and right-sided chest pains. It will be noted on comparing print one and print three that the right border of the cardiac shadow in the latter print is straight, that the cardio-hepatic angle is almost obliterated and at this point there appears to be a slight thickening of the shadow cast by the convexity of liver and diaphragm; moreover many whitish lines can be seen in the negative over the lungs and heart—the above points being suggestive of pleural and pericardial adhesions—but of more immediate interest is the aortic shadow which is here evident not only to the left of the vertebral shadow but also to its right, in other words the shadow cast by the descending thoracic aorta is much wider than the shadow cast by the normal sized vessel and betokens a dilatation of that artery. The pain along his dorsal spine was relieved by potassium iodide.

Print No 4 is of even more interest. The patient was a lady 70 years of age, who ten years previously had been treated for gastric ulcer, she at that time living on liquid food for six months. She had been well up to two years ago, since when she had been subject to attacks of intense localized epigastric pain

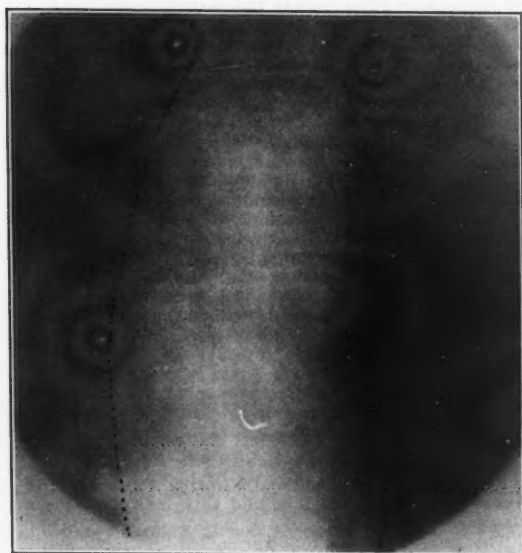


Fig. 4. The dotted lines mark the borders of the dilated vessel.

and to a duller more continuous pain accompanied by throbbing in the epigastric region. In a year she had lost 20 pounds and her condition had been ascribed to cancer of the stomach or aneurism of the abdominal aorta. Examination showed a thin non-anemic woman with slightly yellow conjunctivæ. At intervals, Murphy's manoeuvre caused pain, Robson's point was extremely tender and the right eighth, ninth and tenth segmental nerve areas hypersensitive. In addition a well marked systolic bruit was always audible in the epigastric region, beginning a little above the xiphisternum and being transmitted into both femorals. Pulsation was very marked but no tumor of any kind was palpable. The vessels elsewhere did not pulsate unduly. There was no cardiac murmur. Potassium iodide and rest in bed would cause temporary disappearance of the dull

aching pain and the subjective sense of pulsation. The bruit persisted and in all postures. After much eliminative work the clinical diagnosis was cholecystitis with adhesions and a dilatation of the aorta high up between the pillars of the diaphragm. I took many plates but entirely failed to get evidence of any such dilatation till finally common sense came to my rescue and suggested that the dilatation might be supra-diaphragmatic. Then my search was rewarded and I present Print No. 4, which shows a distinct fusiform aneurismal dilatation of the descending thoracic aorta, best marked at the level of the ninth and tenth dorsal vertebrae. Operation followed by a modified Carlsbad course relieved her gall bladder condition. She still has to take small doses of potassium iodide for the relief of the throbbing and dull pain due to the aneurismal dilatation.

Addenda.

A fifth patient seen since these prints were presented complained of left sided dull chest pains of fifteen years' duration, corresponding in area to the middle chest zone. During the last six months he had suffered from periodic severe pain of an angina character. His heart was large, second aortic sound accentuated, systolic blood tension 210-220 m.m. hg. Peripheral vessels thickened. Field of cardiac response good. The Huchard postural inversion of pulse rate was present. Urine, specific gravity 1.025, free from albumen, casts and sugar. The clinical diagnosis was general arteriosclerosis. It seemed probable that the chest pain depended upon involvement of the descending thoracic aorta, the more recent angina pains upon an extension of the process to the root of the aorta or to the coronary arteries. The Radiogram verified our suspicions in a striking manner showing a well marked dilatation of the upper part of the descending thoracic aorta. In one patient who had similar right sided chest pain the autopsy demonstrated extensive arteriosclerosis of a dilated descending thoracic aorta with an almost entire obliteration of the mouths of the intercostal arteries. The association of such with the pain in the areas supplied by the intercostal vessels was extremely suggestive. Such pains are not necessarily radiating nor do they definitely correspond to any intercostal nerve spinal root or segment area.

PRELIMINARY REPORT ON EPIDIDY- MOTOMY IN THE TREATMENT OF BLENORRHAGIC EPIDIDYMITIS.*

By L. BAZET, M. D., San Francisco.

THE greatest and quickest relief in the treatment of blenorragic epididymitis is accomplished by epididymotomy.

Like appendicitis, this affection ought to be considered a surgical one. In its evolution the morbid process is contained in a closed cavity and the septic secretions cannot be drained. In all cases we have pain, fever, swelling and a decided leukocytosis from 12,000 to 27,000. Once epididymotomy is performed it is a surprise to notice its good effects; the pain stops, the fever falls, leukocytosis subsides; there are no relapses, and the cure is obtained rapidly.

In going over the history of this affection as far back as 1838 we find that orchitis and epididymitis, if not the same disease, at least were subjected to the same treatment.

At that time Ricord said "that there was no blenorragic affection of the organs contained in the scrotum without a swelling of the epididymis." He further demonstrated that it was not the testicle that was primarily affected, and that if it did become involved, it was only by propagation, and to a small extent only, the chief lesion being in the epididymis.

In 1876 Reclus proved that the periepididymitis is greater than the epididymitis itself. To-day we find

* Read before the San Francisco Polyclinic Gathering.

the lesions begin by an endo-deferentitis, and are followed by endo-epididymitis, interstitial epididymitis and a predominant periepididymitis.

Of all the parts of the genital apparatus that blenorrrhagia affects, the epididymis shows us the most constant and the deeper lesions; it is increased in volume two to four times, and in its cavity we find small nodules of the size of a lentil, or of a pea, containing a puriform liquid; these nodules are nothing more than abnormal dilatations of the epididymis, plugged with a mass of various leukocytes imbedded in coagulated serum. The tubes appear permeable. In some of the tubes the epithelial lining has desquamated, the continuity is broken and the pus cells have wandered into the adjoining connective tissue. This connective tissue is quite heavily infiltrated with lymphocytes, its blood vessels injected, and some of its fibrillae forced apart by serum transudate.

The treatment of this affection was identical from 1857, in the time of Curling and Gosselin, with what it was in 1900. It consisted of rest, anti-phlogistics, anodynes, refrigeration, compression, tapping of the vaginalis (Velpeau), incision of the testicular albuginea (Vidal de Cassis). Up to this latter date it was a timid treatment, a disarmed expectation, sacrificing to atrophy and sclerosis a muscular apparatus so necessary to the progression of the sperm.

In October, 1903, Baernaman, assistant professor of Neisser, treated 28 cases of epididymitis by puncture and, in the liquid aspirated, he found the gonococcus; he found also that the serum of these patients had often the power of agglutination for the gonococcus. Its results after the puncture were cessation of the local pain, disappearance of the sensation of tension, fall of the fever. No accident followed the puncture; the extreme pain was the only objection. No mention is made by him of leukocytosis, at least I have not read it in the translation.

In April, 1905, Belfied of Chicago, in an article in the *Journal of the American Medical Association*, entitled: "Pus Tubes in the Male, and Their Surgical Treatment," advocates the incision of the epididymis and its drainage by stitching the cut edges of the cavity to the cut edges of the skin.

Without asking priority for the operation, which has been witnessed by many of my assistants and many physicians in various hospitals, and at dates going as far back as 1897, as shown by the records of the French Hospital, I submit to-day what I consider to be a contribution to the surgery of this affection.

In 1897 I performed my first operation at the French Hospital with the following technic: I chose the ligamentum scrotalis for the incision. We know that the globus minor of the epididymis adheres to the testicle by a layer of very thick connective tissue; the globus minor of the epididymis is outside of the vaginalis and the respective relations of the globus minor, of the epididymis, of the inferior pole of the testicle, of the vaginalis, and of the scrotum are maintained by the ligamentum scrotalis Pasteau. It is at this point that there is no danger of wounding the testicle or opening the vaginalis. Seizing firmly the swollen indurated nodule of the globus minor of the epididymis in the left hand, an incision one inch long is made downwards into the cavity of the epididymis. At first the swollen nodules were punctured and the walls of the cavity were stitched to the incised skin; later on I performed partial epididymectomy,—that is, I extirpated the nodules hoping that anastomosis among the tubules could be made; but, after a case of double epididymitis operated on in this way had resulted in sterility, I changed my technic and now I perform an epididymotomy, that is, I open the cavity of the epididymis, as before stated, expose the nodules, relieve the tension, puncture the nodules, if pus is present, and stitch the walls of the epididymis to the skin. The wound is packed with gauze impregnated with 1-10 ichthyl and glycerine and the organ well supported. The wound heals in a week; the patient is able to be up in four to seven days. Compare

this with the conservative treatment; the recovery is greatly in favor of the epididymotomy.

The cases treated by epididymotomy are getting on well; as quickly as the cases treated by puncture or by extirpation of nodules; further, the danger of sterility by this method is lessened.

I think that there is a great opening for this operation in the army and navy, as the cessation of pain, fall of the fever and ultimate recoveries are more quickly obtained than by any other treatment.

In the last eight years I have operated on 65 patients in the following hospitals: French Hospital, 43; City and County Hospital, 19; the United States Presidio Hospital, 1; the Waldeck Sanitarium, 2. The operation is benign; it ought to be performed as soon as the disease is diagnosed.

I have found the gonococcus in one-third of my cases. I never had any atrophy, nor any hernia, nor any necrosis of the testicle, nor any mortality.

DISCUSSION.

Dr. Reynolds: From my own personal experience I can add nothing to what Dr. Bazet has said. I know that his work has been original and independent, though without having gone over the literature I can not say it is the first work along this line.

After seeing a large number of these cases with Dr. Bazet, I can say that I am heartily in favor of it though it is so radical that one has to see it several times before giving one's sanction. The operative treatment compares favorably with the conservative in every way. The time of the patient in the hospital is no longer, and when they leave there is very little after effect. They are reduced more nearly to the normal than with palliative methods. The time of the operation is short, and if we were in the habit of using gas it could be as well done under this anesthetic. There is no accident, no mortality and no complication to be feared. The fall in temperature is immediate. The patients come into the hospital suffering from fever, pain, leukocytosis and all the signs of an abscess in a confined space, and shortly after the operation the temperature falls to normal, leukocytosis drops, pain is relieved and the patients are put at rest.

I believe the operation, with its most effective technic, causes sterility, but this can be urged as an objection only by those who believe that epididymitis itself does not render the testicle sterile. I do not believe this, and hence think the disease is as likely to sterilize as is the operation. From every point of view I have been completely won over by the operation and shall treat acute cases in this way.

California Public Health Association.

The sixth session of the California Public Health Association will be held in the City Hall, San Francisco, April 16, 1906.

The program is as follows:

10 A. M.—Greeting, by the President.

10:30 A. M.—"The Condition of California Water Supplies," by Dr. N. K. Foster, secretary of the State Board of Health.

Noon recess.

1:30 P. M.—Address by George C. Pardee, Governor of California.

2:30 P. M.—"The Sanitary Quality and Purification of Public Water Supplies," by Professor Hyde of the University of California.

3:30 P. M.—"Sanitary Disposal of Sewage," by George L. Hoxie, City Engineer of Fresno.

4:30 P. M.—One hour devoted to questions and answers.

Each paper will be opened for general discussion immediately after its reading. The discussion of the "Sanitary Disposal of Sewage" will be opened by Dr. Chas. F. Clark of Willits.

The association will meet at the banquet board in the evening, when short addresses of a general character will be indulged in.

PITYRIASIS ROSEA.

By DOUGLASS W. MONTGOMERY, M. D., San Francisco.

In pityriasis rosea, as usually met with, the patient applies for advice on account of a rosy, blotchy rash well distributed over the body. The rash consists of slightly elevated, light red blotches usually about the size of those seen in measles, or in the roseola of syphilis. On looking at the rash more closely, however, many of the blotches are seen to be actively desquamating, and here and there a ringed patch will be found. The outer circle of the ringed patches consists of a bright red line, while the center is a buff color, and is either actively desquamating and branny, or is thrown up into fine parallel wrinkles. The patient is almost invariably in good general health, and can give no idea of how the rash was acquired, but simply says it was first noticed on some part of the trunk, and that it quickly spread over the rest of the body accompanied, perhaps, by some itchiness. In my own records itchiness is recorded in only six out of thirty-eight cases, and in four of these patients the eruption was very itchy, preventing sleep and making them exceedingly uncomfortable. The absence of itchiness is important, as it is looked upon as evidence of the eruption being syphilitic, the gravest and most likely error one can commit.

We rarely have the opportunity of seeing the rash as it commences, because the patients are usually in good health, and a blotch on the skin that does not pain or itch may escape notice, or if noticed, is not considered serious enough to require treatment. Out of twenty-four cases where the patient was questioned about the length of time that the rash was noticed previous to seeking medical advice, four said it existed less than one week before consultation, four one week before consultation, four between one and two weeks before consultation, three two weeks before consultation, six three weeks before consultation, two four weeks before consultation, one five weeks before consultation and one twelve weeks before consultation.

In all probability most of the cases begin by what L. Brocq has called a "primitive patch." This primitive patch is supposed to commence, as the other later blotches do, as a small red spot that subsequently becomes buff colored in the center and spreads at the periphery by a thin, red border. After the initial lesion has existed for a few days the more generalized outbreak occurs. I have never seen the initial lesion existing alone, but have, in some instances, been able to make it out subsequently, partly from the patient's assertion that it was the first patch to appear, and partly from its being larger and having more marked characteristics. But it is the exception to find the initial patch at all, or to get any history of its ever being present. This primary patch is almost always situated on the trunk, but may occur on the limbs. In thirteen cases where I have noted its presence it occurred: On the abdomen in four cases; on the chest in two cases; on the trunk, without designating the particular region, in three cases, and on the limbs in four cases.

As the nature of the disease is not determined, opinions in this regard differ. There are those who hold that it is due to a local infection, and there are others who are equally certain that it is a constitutional disease, due either to an infection accompanied by a rash on the skin, and therefore analogous to the exanthemata, or to some poison generated in the alimentary canal, and therefore analogous to urticaria.

Up till a few years ago the disease used to be called *tinea corporis* or *tinea corporis maculata*, and, in fact, in some large clinics it is still so designated. In referring to my case book I find that as late as fifteen years ago I designated these cases as *tinea corporis maculata*, and of course considered them a form

of ringworm. I had, however, noted that I was unable to find the fungus. Brocq, to whom we owe much of our knowledge of this disease, showed that it begins as a "primitive patch," shortly afterwards becomes generalized, and then spontaneously clears up. It is said to occupy in its natural evolution about six or eight weeks. No ringworm disease runs any such course. Besides, many careful observers are absolutely unable to find any trace of a fungus. It has been said that the fungus is found only after a most careful search, and some have stated that it is only encountered at a particular time in the evolution of the disease. Kaposi said he found a vigorous growth of mycelium in a patient whom he demonstrated before the Vienna Dermatological Society, February 22, 1899, and Neumann, at the same meeting, said he was able to demonstrate the mycelium in such cases by soaking the scales in xylol¹. These findings, however, are so isolated that they serve only to accentuate the negative side of the question, for if the mycelium were present it would surely be frequently found by the many enthusiastic investigators in this field.

It has been urged, as above indicated, that the rash is due to a constitutional disturbance, and that this disturbance occurs before the appearance of the rash, and that the general symptoms have disappeared before the patient consults a physician. If there are any such general constitutional symptoms in pityriasis rosea they must be slight, for in my experience the patient is unable to give any definite account of them.

Of thirty-eight cases, the histories of which I have looked over, only a few gave any account of symptoms of a general nature, and such as are apt to occur in any group of cases. One patient complained of polyuria. A man said that during the first few days of the generalized rash he had noticed that the urinary secretion was not as large in amount as usual. He had not measured it, however, and when I examined it, it was normal. Another complained of brick-dust sediment in the urine, and still another that he had a burning sensation on urinating. Jacquet has said that patients having pityriasis rosea suffer particularly from dilatation of the stomach. This view has not received much support from other observers. In my experience symptoms referable to the stomach or bowels have been absent or unimportant. One patient, when she first noticed the rash, two weeks before seeing me, had pains in the stomach and looseness in the bowels. Another patient had pains in the stomach, another indigestion, and another heartburn. In another case the patient is noted as having a much enlarged liver. In five cases there was constipation, in two there was abnormal looseness of the bowels, and in one there were black ill-smelling stools. In two instances there was anemia, and in one the patient complained of headaches. As far, therefore, as general symptoms were concerned, nothing extraordinary was noted; nothing that one would not expect to find in an equal number of people drawn from the general population.

As the disease strikingly resembles seborrhea, especially seborrhea annulata, it is thought by some to be a seborrheide, and so to belong to the group of diseases including seborrhea sicca and oleosa, seborrheic eczema, acne, and psoriasis. The resemblance is often so close between pityriasis rosea and seborrhea annulata that some most acute clinicians like Besnier admit, in some cases, not being able to make the diagnosis between them. If this view be correct, then pityriasis rosea would be a skin manifestation of a constitutional trouble, as the seborrheides certainly are, and should frequently be accompanied by other manifestations of seborrhea. The following is the list of skin diseases found in my patients having pityriasis rosea:

Seborrheides—Three patients had seborrhea sicca capitis, two defluvium capillitii, three alopecia, two

¹ *Ann. de Derm. et de Syphil.*, Serie iii, Tome X, p. 865.

blepharitis ciliaris, two acne, one psoriasis, three seborrheic eczema. Other diseases of the skin—One patient had urticaria, one impetigo contagiosa, two eczema, one herpes simplex, one sycosis vulgaris, one pityriasis versicolor, one lichen planus, three syphilis.

Of the above 16 seborrheides 12 occurred in six patients, that is to say six out of 38 patients were frankly seborrheic. Considering the fact that seborrhea is the daily bread of a skin disease specialist's work, this would not attract attention; but if this represents the real relationship between seborrhea and pityriasis rosea, then it could be said that those having seborrhea are unusually prone to having pityriasis rosea.

Sabouraud has recently investigated pityriasis rosea, and concludes from the pathologic histology of its lesions that it is a polymorphous erythema, due to some internal cause of unknown nature².

Although many observers, possibly most of them, are now of the opinion that pityriasis rosea is a cutaneous manifestation of a constitutional disturbance, there are many facts difficult to explain on this hypothesis, and the most striking of these facts is the "primitive patch." This appears a considerable time before the generalized eruption and just exactly as if it were the seat of first inoculation, from which the virus afterwards spread. The "primitive patch" is better marked than the lesions of the subsequent rash, like the lesion of inoculation in many undoubtedly infectious diseases. Peripheral extension, with central clearing of the lesions, is strongly suggestive of parasitism, but is not conclusive, as there are diseases of the skin not due to local parasites that act in this way. There is also the fact that although the idea that this disease was a ringworm was erroneous, yet the men who held this idea were clever clinicians, and always considered pityriasis rosea a parasitic disease of the skin. It undoubtedly gives the impression of being a local parasitic disease, and the results of treatment also favor this view. In this regard we must admit that in every self-limited disease with a wide variation in the time of its duration, it is difficult to determine the good effected by any mode of treatment. For instance, although the duration of this disease is set down as from six to eight weeks, yet we do not see the patient till the disease has run for some time, and the longer it runs without treatment the nearer the disease is to its natural termination. Then, again, many cases run a much longer course than the time given as the average; some have been known to endure for even a year before clearing up. Nevertheless, with all this taken into account, I do believe that the treatment instituted by Jamieson, and advocated by Norman Walker, is of benefit, and that it shortens the course of the disease. This treatment is entirely local, and therefore lends support to the idea that the disease is due to a parasite of the skin. In spite of these indications that the disease is produced by a local contagium, it is very rare indeed to get any evidence even hinting toward the transmission of the disease from person to person. A patient having pityriasis rosea, told me that a week before the appearance of the rash he had slept with a man having a rash. He was not able to describe the other man's rash with any particularity, so, of course, his evidence was of very little value. In another instance a patient told me he had used a strange bathing suit that chafed in the axilla. The primary patch appeared in this axilla shortly afterwards.

As showing the time of evolution of pityriasis rosea I have seen six patients who were under treatment for other maladies that detained them under my care longer than they otherwise would have remained. In them I was able to ascertain with fair exactitude when the disease began and also to observe when the rash definitely disappeared. In one case the rash lasted one week, in one case the rash lasted two weeks, in one case the rash lasted three

weeks, in one case the rash lasted four weeks, in one case the rash lasted five weeks, in one case the rash lasted six weeks, in one case the rash lasted four months.

In some cases it is impossible to make the diagnosis between seborrhea annulata and pityriasis. There are the same light-red rings with buff wrinkled centers in both affections. Usually, however, the rapid distribution of the rosy rash is sufficient to differentiate the affections. In measles there are the severe constitutional symptoms, the catarrhal affection of the nose and throat and bronchi, the presence of the rash on the face, an unusual situation for pityriasis rosea, and the absence of the rings with the buff colored wrinkled center. In German measles, because of the slighter constitutional symptoms, the diagnosis may be more difficult, but there is the same absence of the peculiar rings. In the diagnosis between pityriasis rosea and the roseola of syphilis the gravest errors may occur. This diagnosis is especially imminent if the patient has at the same time a venereal sore, together with a fresh rosy eruption of pityriasis rosea. The first search should be for the "primitive patch," and if that cannot be found, then a careful examination should be made for small red rings with the skin in the center buff colored and wrinkled. The wrinkling, otherwise unobservable in the early stages, can sometimes be demonstrated by placing the thumb and finger on opposite sides of a patch and then opening them so as to put the skin on the stretch. There is also sometimes in syphilis a red ringed eruption with a desquamating center, that simulates closely a pityriasis rosea. It is a rare eruption, however, and occurs much later than the roseola of syphilis.

The desquamative green soap treatment used to be the favorite, and seemed to give good results. With a moistened hand green soap is rubbed into the whole skin from the level of the jaw downwards, once or twice a day for six days. During another six days the patient simply powders the skin with some indifferent powder while waiting for the separation of the shriveled upper epidermal layers. On the twelfth day from commencing the treatment a bath is taken for the first time, when the whole upper epidermal layers, together with their flora, are shed. A modification of this treatment is to add 2% of napthol to the green soap. This mixture is rubbed in twice a day for two or three days, and not for six days, as in the former case. The rest of the procedure is the same as in the former case. This treatment is disagreeable, oily and irritating, and is not nearly so pleasant nor, to my mind, as effective as that recommended by Allen Jamieson.

For quite a long time I have been using with satisfactory results Jamieson's treatment published by Walker in his "Introduction to Dermatology," which runs as follows: The patient should be soaked daily for half an hour in a bath to which two or three teaspoonfuls of Condy's Fluid have been added, after which acid salicylic acid 3 to 5, vaseline 100, is applied freely to the skin.

THE PATHOLOGY AND TREATMENT OF TETANUS.*

By T. C. McCLEAVE, M. D., Berkeley, Cal.

A YEAR ago, in discussing a paper on tetanus before this Association, I called attention to certain newly-discovered facts regarding the manner in which the tetanus toxin reaches the spinal cord, and I stated at that time that these discoveries would no doubt lead to improvements in the methods of treatment of this dreadful affection. During the year, so much of value in this connection has been published, that I have thought it worth while to review briefly at this time the whole subject of the pathology and treatment of this disease.

Revue Pratique des Maladies Cutanees, Syphilitiques et Veneriennes. June 1, 1902.

*Read before the Pacific Association of Railroad Surgeons, August 17, 1905.

Tetanus is caused by the development within the tissues of a specific micro-organism, the bacillus tetani. The bacillus probably in every case gains access to the body through a wound, either of the skin or mucous surfaces, though the wound may be so inconspicuous as to escape attention, as in cases of so-called idiopathic tetanus. This organism is a normal inhabitant of the soil, in tropical and temperate regions, and is especially found in garden soil and elsewhere where the ground has been contaminated by the intestinal discharges of the herbivorous animals. While its distribution is general, its virulence differs greatly under various circumstances and in various localities. Thus there are in Louisiana, New York, New Jersey, and in our own southern California and other places, certain well-defined areas where the germ is particularly virulent, and where the disease at times attains endemic proportions, making it necessary in these regions to take extraordinary precautions against infection. The germ is an anerobe, and tetanus is therefore common in cases of punctured wounds and others of a character which renders access of air to the deeper parts difficult.

The incubation period is variable, from a few days to even weeks, but it may be said that as a rule the shorter the incubation period the more virulent the disease. The severity is also increased in case of tetanus infection of wounds presenting considerable destruction of tissue and especially where there is a mixed tetanus and pyogenic infection.

In suitable cultures and in the tissues, the growth of the organism is accompanied by the production of an exceedingly potent toxin, the tetanic spasms being due to the action of the toxin upon the cells of the motor tracts of the central nervous system. All other cells of the body are unaffected by the toxin unless we except the red blood cells, for it has been found that the toxin consists of two bodies, one of which is hemolytic and the other produces the spasms, (tetano-lysin and tetano-spasmin).

For the most part, the growth of tetanus bacilli in a wound is not followed by the distribution of the organisms throughout the body, they being limited to the immediate neighborhood of the wound, and only in rare instances being demonstrable in the blood and internal organs. The toxin, then, is elaborated at the point of inoculation, and the question to which I desire to direct your especial attention is that of the manner in which it reaches the spinal cord, in determining which some recent observers, (Marie, Morax, Meyer, Ransom) have brought out facts of the greatest possible interest and practical importance, showing that it is along the axis cylinders of the motor nerves that the toxin is transmitted. The toxin appears to enter the nerve trunk only beyond the medullary sheath, or in other words, at the nerve terminals. A large part of the toxin gains direct access to the terminals in the vicinity of the point of inoculation, while the balance is taken up and distributed over the entire body by the circulation. In this way toxin is carried everywhere to the terminals of motor nerves, and all such nerves probably share in the process of absorption. The sensory nerves, however, do not take up the poison. From the nerve terminals, the toxin appears to be transmitted along the axis cylinders to the motor tracts of the cord, and then upward along these to the medulla. The process is the same whether it result from an accidental wound, or an experimental inoculation of tetanus toxin, and even if toxin be injected into the subdural space, it is only by way of the circulation and the motor nerves that it finally reaches the cord.

The tetanus toxin is found in the body only in the blood and tissues of the central nervous system, and it was this which led the investigators previously named to seek in these tissues the explanation for the phenomena of the disease. In their experiments they showed that toxin injected into the tissues can shortly be demonstrated in the motor nerves of the

part; that if the nerve containing toxin be severed, that portion distal to the cut retains the toxin, while it gradually disappears from the proximal portion and is later to be found in the spinal cord; that severance of a nerve or of the cord prevents the passage of toxin beyond the point of severance; that nerves whose axis cylinders have been caused to degenerate by being cut some days before the experimental inoculation absorb no toxin at all; and that very small amounts of toxin injected directly into a nerve produce fatal tetanus much more quickly than larger amounts injected into the tissues or into the blood. These and other experimental findings would appear to fairly substantiate the theory that the toxin finds its way from the periphery to the cord by way of the motor nerves.

Treatment.—We have in tetanus antitoxin an agent which, when brought in direct contact with the toxin is a chemical antidote to it, and yet as a curative measure it has proven very inefficient as heretofore used by subcutaneous injection, the reason for which is now evident. When tetanus antitoxin is injected into the tissues it has been found that it is slowly taken into the circulation, partially destroyed and partially carried off in the excretions, finally disappearing altogether, and none is absorbed by the nervous tissues. Whatever good effect it could have therefore would depend upon such part as would tardily reach the unabsorbed toxin through the circulation. Toxin which has entered the nerves is already beyond reach. This does not mean, however, that the antitoxin cannot be efficiently used. Rogers, of New York, in a recent paper, describes the following method of treatment, reporting seven cases with four recoveries. Since the toxin is everywhere brought in contact with nerve terminals through the medium of the circulation, the first step in treatment is the attempt to neutralize this disseminated toxin. Because of its rapid absorption by the nerves and the slow absorption of the antitoxin into the circulation when injected subcutaneously, the only way to accomplish anything in this direction is to introduce the antitoxin directly into the blood stream by intravenous injection, under the most careful asepsis. The larger veins of the arm are most convenient for this purpose. The dose used should be from 10 to 20 c. c. which may be repeated as needed. Antitoxin should also be injected in the neighborhood of the infected wound.

The next step is to interrupt, if possible, the main currents of toxin passing up the nerves having their terminals near the infected wound, especially in wounds of the extremities, and it has been found that this can be accomplished by injecting antitoxin directly into the main nerve trunks of the part as high above the wound as possible, in the case of an infected hand, exposing the nerves in the axilla, and if dealing with an infected foot, exposing those high up in the thigh. Each nerve is then anchored with a ligature and with a fine needle enough antitoxin is injected at several points to swell the nerve to three or four times its normal size. The wounds are then dressed, the ligatures being left in place to facilitate reaching the nerves in the event that subsequent repetitions of this procedure are necessary, for the blocking effect thus produced is of comparatively short duration. In desperate cases, where respiratory and cardiac embarrassment indicate that the centers in the medulla are already being attacked, it is necessary, in addition to blocking the nerves in the manner just described, to also block the cord against the upward flow of toxin, by the injection of antitoxin into the cord itself. This is accomplished by inserting a long slender needle in the lower cervical region and injecting 20-30 minims of the serum. This act is not devoid of danger, especially that of hemorrhage into the cord, but so far no evil consequences have been reported. In less desperate cases, the injection may be made into the cauda equina by lumbar puncture.

The treatment of the infected wound remains to be considered. High amputation of the affected limb will of course remove at once the source of the toxin, and I think it should be done where antitoxin is not available, or where the wound is so extensive and so dirty as to render adequate disinfection impossible. The sacrifice of a limb is deplorable, but not so much so as the sacrifice of a life which amputation might have saved. Small wounds should be freely opened and cleaned out and dressed in such a way as to admit air. Tr. iodine, mercuric bichlorid and carbolic acid, in the order named, are said to be the best antiseptics for use in these cases. Dried antitoxin, used as a dusting powder in the wound, is said to be efficacious, and the entire region of the wound must be injected with antitoxic serum. All the treatment above described, both local and general, must be carried out under chloroform anesthesia and must be repeated daily or oftener until the symptoms subside.

The patient must be kept perfectly quiet in a dark room, and morphin, chloral, and bromids administered as needed for the control of the spasms. Cold, both general and as a local application to the affected part, is said to be useful, and if antitoxin is not obtainable, the method of treatment by means of repeated injections of dilute carbolic acid deserves consideration.

Murphy has reported a case treated by lumbar puncture, the withdrawal of cerebro-spinal fluid, and the injection into the subdural space of a dilute morphin-cocain solution. This procedure, repeated as often as the symptoms demanded, apparently afforded relief from the spasms, and the patient recovered.

Measures which promote phagocytosis may also prove useful, since it is shown by inoculation experiments that a low degree of phagocytosis favors the development of the disease, and vice versa, the bacilli in favorable cases apparently being largely taken up by the leukocytes and destroyed.

Tetanus, however, no matter how treated, will probably always maintain a high mortality rate, and our every effort, therefore, in patients presenting suspicious wounds, should be directed toward prophylaxis. The wound should be treated as previously described for wounds known to be infected, and the patient should receive daily injections of antitoxin about the wound and subcutaneously for not less than two weeks, a sufficient time to cover the possible incubation period. There is every reason to believe that a wide adoption of this plan would greatly lessen the incidence of tetanus.

During the year I have had no opportunity to personally test the treatment of tetanus by the methods I have outlined, and as stated in the beginning, this paper is only a review of the year's literature on the subject, but with the new light thrown on the pathology of the disease, I do not hesitate to recommend nor will I hesitate to use, if necessary, the most extreme measures described.

THE REQUISITE LABORATORY EQUIPMENT FOR THE GENERAL PRACTITIONER.*

By RAY L. WILBUR, M. D., Stanford University.

IN these days of the multiplicity of clinical instruments and clinical tests, it becomes of some importance to the general physician to know how much actual equipment is necessary for laboratory work and how far his time and experience will let him go before he needs to call for the services of a laboratory expert. In the present day medical education enough stress is laid upon all forms of laboratory work so that the average graduate is well equipped mentally for all the ordinary tests. A promi-

nent English physician has recently raised objection to the modern method of teaching largely through the laboratory and has laid emphasis upon the need of more clinical instruction. While there is perhaps some basis for his opinion, still the growth of medicine has become so closely interwoven with the development of the more basic sciences, such as physiology, chemistry, pathology, bacteriology, etc., that a sound training in them is required if one is to keep abreast with advancing medical progress.

As a matter of fact, the number of clinical tests in every day use by the general practitioner need not be very great, and the amount of equipment required is comparatively small. Of course, if one attempts to go deeply into the study of any body excretion, or to do much in quantitative analysis, such an amount of time and apparatus is necessary that one is justified in assuming that all such work should fall into the hands of specialists. Spectroscopy, cryoscopy, nitrogen estimations, the use of the polariscope, etc., can well be left to those with time and equipment for such studies.

The materials from which we learn most, and a study of which is of value in every-day work are the urine, blood, feces, stomach contents, sputum, human milk and perhaps the fluid from lumbar puncture, swabs from the throat, pus examinations, or the various transudates and exudates. For the most part only the first six need to come under immediate observation in routine work, and the latter are better left to the laboratory expert.

The usual information required in regard to the urine is: Quantity in 24 hours; specific gravity; total solids; reaction; the presence or absence of albumen, sugar, bile, pus, blood, acetone bodies, casts, crystals of various sorts, epithellum and occasionally the kinds of bacteria.

To ascertain most of these things requires only a moderate amount of time and no particular training, and about the following apparatus: (1) Various simple reagents, funnels, graduates, etc.; (2) urinometer; (3) microscope; (4) centrifuge.

With the exception of the microscope, which is an absolute necessity, the expense of the above is not very great, and now a satisfactory microscope can be purchased at a reasonable figure. The centrifuge can be dispensed with and sedimentation glasses used, but more time is required and decomposition of some of the organic deposits may ensue.

The simple tests for albumen, heat and acetic acid, the HNO₃ test and the Haines' or Fehling's test for sugar require only a few test tubes and bottles. The microscopic work requires a little more time, but is of very great value. The failure to make microscopical examinations of urinary sediments often allows our cases to leave our hands imperfectly understood, particularly is this true in men with beginning changes in the kidney vessels where urine of low specific gravity is passed, with or without a trace of albumen in the urine, but usually with hyaline casts sparingly present in the sediment. A careful study of urinary sediments, such as that of Emerson of Johns Hopkins Hospital (*Journal of A.M.A.*, XLVI, Nos. 1 and 2), has shown how necessary it is for us to make microscopical as well as chemical examinations, and yet how lacking in clinical significance the presence of casts may be. How many men have been told they had Bright's Disease when a trace of albumen was found in the urine, when a careful microscopical examination would have shown they were only suffering from the after effects of a former gonorrhea, or had a beginning prostatitis. A more thorough understanding of urethral discharges of various sorts and of expressed prostatic fluids would save many a victim from the advertising quack and make many a life happy.

Fortunately no particular expertness is required for a study of urinary sediments, and by the aid of a blue glass this work can be done night or day, so that the

*Read before the Santa Clara County Medical Society, January 20, 1906.

general practitioner can usually find time to do it for himself.

So many excellent books on chemical and microscopical examinations are available that one can readily learn to recognize the ordinary constituents of sediments without special teaching.

While the urine has long been a subject of medical inquiry, it is only within more recent time that the blood has come under daily medical notice from its chemical and microscopical side. The usual information desired is: Percentage of hemoglobin; enumeration of the red and white blood corpuscles; differential count of the whites; presence of malarial organisms; Widal test; specific gravity. For this work is required: (1) A simple hemoglobinometer; (2) a microscope with a few reagents; (3) a typhoid culture and microscope or Widal test outfit; (4) a urinometer and two simple chemicals—for specific gravity).

Ordinarily the amount of hemoglobin and the proper study of a smear will teach us all that we need to know. Only a man with considerable time at his disposal will be able to do his own blood counts or microscopical Widal reactions.

The amount of hemoglobin can be approximately ascertained in a few seconds with the Tallquist hemoglobinometer, although the instruments of Gowers, Dare, Von Fleischl and Sahli are perhaps more satisfactory. Since the Tallquist has no very great error it can be used with assurance for ordinary cases, reserving the more complicated instruments for special ones.

The enumeration of the corpuscles requires besides the microscope, the graduated pipettes, special glass slips and special solutions and requires some time. Ordinarily this method of acquiring information can be dispensed with or turned over to the laboratory specialists, unless in an acute case the number of white corpuscles is of immediate importance. By the use of Ehrlich's stops one can approximate readily the number of corpuscles, both red and white, as well as do a differential count from the ordinary smear. For rapid work this is often of much importance, as the pipettes are dispensed with and one need carry only cover glasses and the Tallquist hemoglobinometer into the sick room. Then by the use of Wright's stain, which fixes as well as stains, one is ready for immediate work. Differential counting is of some importance in acute cases, but can readily be left until time is available or in the various anemias, etc., sent to a laboratory for special report.

The presence of the malarial organism is not difficult to ascertain, particularly if one can examine fresh blood obtained during the fever following a chill. While stained specimens can be readily used, malarial organisms are so easily recognized in fresh blood and the immediate information is of such therapeutic value, that the practitioner should always attempt such examination in suspected cases.

The Widal test with the microscope is perhaps better done by the laboratory specialist, as the handling of live typhoid cultures is dangerous and ease of manipulation comes only with constant practice, but the grosser Widal tests, with the various agglutometers and dead typhoid cultures, is simple and can be safely done in every-day work. The specific gravity of the blood, the coagulation time, etc., are not required for every-day information and can be easily provided for in case a study of them is desired.

The feces do not receive from the general practitioner as much attention as they merit; particularly is this true in acute illnesses and in infantile disorders. The gross inspection, combined with a few simple chemical tests, is all that is usually required to estimate the undue presence of fat or proteid or other undigested food, the absence or presence of bile or derived bile pigments, the presence of blood, gall stones, mucous, etc., or the larger animal parasites. The microscopical examination for amebæ, the

various parasites or their ova can readily be carried out in special cases or turned over to the laboratory. The chemical tests, estimation of nitrogen, etc., do not come within the province of the general practitioner.

The chemical study of the stomach contents often gives such useful information that every physician should be prepared to make it. The apparatus and chemicals required are few and simple and the tests easy of recognition. It is not necessary here to go into the qualitative and quantitative test commonly used. The only apparatus needed is graduated burettes, beakers, test tubes, evaporating dishes, and graduates and a few chemical solutions readily obtained from a dealer in microscopical or chemical supplies.

The sputum is, as a rule, of interest to us largely from a microscopical standpoint, and beyond the ordinary staining methods for tubercle bacilli, streptococci and the search for elastic fibers, Curschman spirals or the various crystals there is no usual occasion for its study by the busy practitioner. Here no apparatus beyond the microscope and a few stains is required.

Human milk is so easily analyzed, as regards its more important constituents, that one is surprised how comparatively few physicians avail themselves of the opportunity to readily acquire reliable information about the food of nursing infants under their charge. A simple Holt's test outfit is as reasonable in price as it is valuable as an aid, and it requires but little time to run the few requisite tests through.

The other substances for laboratory investigation that come before us are perhaps better left to the clinical pathologist, still any one can arrange a satisfactory incubator with a wooden box, a thermometer, and an incandescent light and study cultures, made on ready purchased media, from throats, abscesses, etc. With the equipment enumerated for the blood and urine an interesting or unusual case could readily be studied from its microscopical side, and we should all be prepared to do such things as stain for the gonococcus and identify with some accuracy the organism from an abscess.

I trust that it is clear from what has been said that the usual laboratory work of the practitioner does not require an inordinate amount of expensive apparatus, or any great skill or experience. There are so many simple tests that teach us so much about our cases that we should all attempt to bring them into practical every-day use, leaving the more complicated chemical or bacteriological researches that confront us in some cases to men especially trained and equipped for such work.

GASTROENTERIC AUTOINTOXICATION; ITS RECOGNITION AND SIGNIFICANCE, AND ITS RELATION TO ARTERIAL HYPERTENSION.*

By W. A. BRIGGS, M. D., Sacramento.

THE physiologic and the pathologic problems of digestion and of the digestive tract are obviously fundamental. Not only are they fundamental, but, both from a theoretical and from a practical view-point, they are anthropologically universal. They implicate every tissue and every function—nay, more, the very destiny of nations. Many a philosophy is tinged with black bile, and many a world policy is implacably determined by the colon bacillus.

In recent years physiologists, bacteriologists and clinicians, notably Pawlow, Metchnikoff, Chittenden and Federn, by their patient and ingenious labors, have thrown much light on various aspects of these problems. It is particularly to these investigations, interpreted by my own clinical experience, that I invite your attention this evening.

*Read before the Yolo Society for Medical Improvement, Nov. 7, 1905.

Chronic gastroenteric autointoxication may persist during a long period and produce marked secondary changes, may even reach the terminal stage of exhaustion of the cardiac reserve, without having developed local symptoms, either gastric or enteric, sufficiently pronounced seriously to attract the attention of the patient.

In speaking of partial atony of the colon so often associated with severe forms of toxemia, Federn not inaptly compares it to certain abnormalities of the uterus, as, for instance, flexions and erosions, which often cause only quite insignificant local symptoms, and yet provoke painful and profound disturbances in distant organs.

In the diagnosis of partial atony, Federn places the patient's body in a perfectly horizontal position with the knees and hips slightly flexed. If necessary for the patient's comfort, the head may be slightly raised, but not the shoulders. Percussion may then be made but very lightly, over the colon, beginning with the cecum and following its course to the sigmoid, using one finger of the left hand as a pleximeter, and percussing from finger-breadth to finger-breadth along the whole course of the colon, so as to determine the condition of every segment, even the smallest.

On these points—the position of the body and the precision of percussion—Federn lays great stress. Dullness indicates accumulation of fecal matter and atony. Tenderness usually exists over such areas and may be developed by deep pressure.

In these cases either constipation, constipation alternating with diarrhea, or even diarrhea without constipation, is usually present, and Federn believes that all, or at least the great majority of cases of chronic, idiopathic, intestinal catarrh are caused or complicated by partial atony of the colon.

I refer thus explicitly to Federn, because in all the literature at my command I have been able to find nothing else quite so illuminating, both from an etiological and a therapeutic point of view, as his various papers on blood-pressure and atony of the colon.

After ascertaining the condition and position of the colon, the stomach should be carefully mapped out, so as to determine what, if any, influence this organ may have in any possible aberration of total motility. In case of dilatation or displacement of the stomach, its motor function should be investigated.

After a careful physical examination, I have been for several years in the habit of testing the total motility of the gastrointestinal tract. This may be done by any innocuous substance which colors the stools without in any way influencing the motor functions of the digestive organs. I have experimented with methylene blue, bismuth and charcoal. Methylene blue is occasionally absorbed so entirely as to leave only an indistinct trace in the stools; bismuth is somewhat constipating, so that latterly I have employed charcoal exclusively for this purpose. I order six tablets, two of which are to be chewed fine and swallowed after breakfast. When these two have passed the bowels entirely, two more are to be taken in the same way after luncheon; and when these have passed, two more after dinner.

The patient is instructed to take careful observations and notes showing when the first charcoal passes, when the bulk of it, and when the last. In this way I am able to judge accurately of the motor functions of the digestive tract as a whole. Knowing the total motility and the gastric motility, it is only a question in subtraction to ascertain the motility of the intestines.

In doubtful cases it is well to determine the acidity of the stomach after a test meal; for, *a priori*, we might expect, and practically I have found, that in a large percentage of cases of gastroenteric autointoxication there is either *achylia gastrica* or marked sub-acidity. If the gastric digestion is very feeble

or entirely arrested and the normal acid stimulant of hepatic, pancreatic and intestinal secretion is greatly or entirely lacking, is not intestinal digestion likely to be correspondingly slow and imperfect, and intestinal putrefaction correspondingly active? Such, in fact, we find to be the case.

Next we should look for evidences of decomposition of contents of the intestine: offensive stools, spongy stools, offensive gas per rectum, offensive breath, offensive urine and indicanuria. A muddy or sallow complexion is often present in these cases, even a distinct jaundice of hematogenic origin, especially, perhaps, when the catarrhal process invades the appendix. Two such cases I have seen recently. Urticaria and, less frequently, erythema, may occur greatly aggravated in the acute exacerbations. It goes without saying that bacteria and their toxins often produce catarrh of the stomach and the intestines; but they often also irritate and inflame distant mucosa—of the nose, pharynx, bronchi—producing and aggravating catarrh and markedly diminishing their resistance to bacterial invasion.

Case 1. A merchant, 38 years of age, had complained of urticaria intermittently for several months. Sent for me on account of harassing cough, with severe nocturnal paroxysms. He ate freely of meats and indulged his appetite generally. The urticaria and extreme irritability of the membranes made me suspect their gastrointestinal origin which a careful investigation confirmed. The usual cough remedies had very little effect, but laxatives and restricted diet brought relief. This history was repeated again and again, but unfortunately the patient preferred Bacchus to Esculapius, and therefore has not had continuous and systematic treatment.

Case 2. A traveling salesman, using tobacco freely, drinking at times to excess, and a high liver, came to me with a systolic pressure of 190mm, marked mental depression, dyspnea on exertion, and severe urticaria. The bowels were constipated and the transverse and descending colon atonic. The urticaria was distinctly connected with toxemia due to errors in diet and drink.

Under laxatives, nitrates and a careful diet he got in six months entire symptomatic relief and a systolic pressure of 130mm. Resumption of his previous habits, however, soon brought on the old train of symptoms, which were again relieved by return to the previous regimen.

In this case the causal relation between the gastrointestinal autointoxication on the one hand and arterial hypertension, mental depression and urticaria on the other seems unquestionable.

Infection or toxemia of intestinal origin often produces rheumatism. I am quite positive that I have seen acute rheumatism develop in this way. For this reason laxatives, antiseptic enemata and other means of disinfecting the gastrointestinal tract have found, I believe, a useful place in my therapy of certain cases of rheumatism.

Case 3. L—was taken with an acute indigestion, and two or three days later with acute articular rheumatism of severe type. Following the acute indigestion came an extremely profuse and fetid diarrhea. I gave oil, salicylates and naphthalin by mouth and washed out the colon thoroughly with crocin solution alternating with sterile salt solution. I was profoundly impressed by the association of marked virulence of the disease with prompt and complete recovery under vigorous intestinal antiseptics, and ever since have regarded the gastroenteric tract as the probable source of infection in many cases of acute rheumatism, sharing this unenviable distinction with the tonsils. Chronic rheumatism, particularly of the muscular type, is often associated with chronic bowel infection, and often disappears under treatment intended to relieve the bowel condition.

Case 4. B—consulted me in November, 1904. He had suffered from myalgia for three years, with frequent exacerbations.

Three months of lacto-vegetarian diet with mild laxatives and Faradization of the intestines produced entire relief of the rheumatic symptoms, which continues to the present.

On account of toxemia and of diminished powers of digestion and absorption, anemia is quite common in gastroenteric autointoxication.

Case 5. Mrs. E—sent for me in great haste one night in August, 1903. I found her in a state of great apprehension with extreme tachycardia; pulse, 180. She had an enteritis of long standing with profuse mucus discharge, ptosis of right kidney, stomach and colon, and atony of the descending and transverse colon. The immediate attack was unmistakably connected with toxemia of intestinal origin.

The tachycardia continued for three days with nocturnal exacerbations, and recurred at irregular intervals until late in September, when I left for the East. After my return she came to my office in June, 1904. She gave a history of several months of sanatorium treatment, change of climate and medication, without material benefit. Ex-

amination confirmed the presence of conditions already described, and in addition a decided anemia. Dare's hemoglobinometer indicating a hemoglobin content of 33 per cent only.

Rest, a careful but liberal diet consisting chiefly of milk, eggs, cream and coarse farinaceous foods; an efficient abdominal support; the sinusoidal current to the colon; the wave current; vibration; eserine and iron, produced a slow but satisfactory improvement, amounting in five months practically to symptomatic recovery.

The kidneys also are irritated by toxins and bacteria. The urine is often heavy and high-colored; traces of albumen appear with the exacerbations, and not infrequently a chronic nephritis is finally established. Sooner or later peripheral irritation of the splanchnic, or direct excitation of the vasomotor centers by ptomaines and toxins, causes arterial hypertension; toxins and perhaps bacteria invade the arterial walls, and degenerative processes set in. At first, hypertension may be intermittent, but later it becomes permanent, and then, unless intelligent aid is seriously invoked, the beginning of the end is in view.

The pathogenesis of arterial hypertension is complicated, and, in many respects, obscure. An immense amount of experimental work, however, has been done by Ludwig, Tigerstedt and numerous others, which, at least in its net results, it may be well for us to consider in this connection.

"In any individual," says Janeway, "the blood-pressure, at any given moment, depends on four separate factors: (1) The energy of the heart; (2) the peripheral resistance; (3) the elasticity of the arterial walls; (4) the volume of blood."

Increase of any one of these factors, other factors remaining equal, increases blood-pressure, and diminution of any factor diminishes it.

Obviously, the total end-pressure of the arterial circulation is determined by the effective energy of the ventricular systole, possibly increased by the muscular contraction of the arterial bed itself, and diminished by the loss in friction.

Arterial tension is regulated by a vasoconstrictor center situated in the medulla oblongata, and subsidiary vasoconstrictor centers, and by vasodilator centers in the lower cord, like other centers receiving and transmitting impulses through afferent and efferent nerves which have been demonstrated in every important organ with the exception of the brain.

As a rule, stimulation of centripetal nerves increases the vascular tone and raises blood-pressure.

A few centripetal nerves like the splanchnic, for instance, contain both vasoconstrictor and vasodilator fibers, the latter responding to milder, the former to more active stimulation. Only one nerve in the whole body—the depressor—is exclusively vasodilator.

Stimuli from various organs and tissues reach the vasometer centers by the centripetal nerves, and are reflected to the different vascular areas either as vasoconstrictor or as vasodilator impulses.

While practically all of the afferent nerves participate in the vasomotor function, one, the splanchnic, because of its sensitiveness to vasomotor influences, and because of the enormous vascular area it controls, overshadows all the rest. This nerve and this vascular area, the splanchnic nerve and the splanchnic area, are the chief factors in the determination of blood-pressure. In this conclusion physiologists, I believe, are practically agreed.

By careful investigation for a long period, Federn has demonstrated what I have repeatedly confirmed—that partial atony of the colon is often associated with arterial hypertension. He assumes that hypertension is brought about by peripheral or centripetal irritation of the splanchnic nerve, due to adhesion of the intestinal contents to the bowel-wall. In other words, he assumes a mechanical rather than a chemical or toxic irritation. I have often found arterial hypertension evidently of intestinal origin in cases

in which, by the methods of Federn, I could not demonstrate the existence of partial atony; and I have found partial atony, as Federn confesses to have done himself, in cases with a normal tension.

Ptomaines, toxins and undetermined poisons of gastroenteric origin may conceivably affect blood-pressure in several ways: (1) By peripheral or centripetal irritations which are reflected from the vasomotor centers; (2) by immediate excitation of the vasomotor centers; (3) by local excitation of the arterioles themselves, after the manner of epinephrin hypodermatically; (4) by either immediate or reflex stimulation of the heart; (5) by the production of arteriosclerosis; (6) by causing nephritis, and disturbing the balance between absorption and excretion; (7) by disturbing metabolism, and favoring the production of toxins which still further influence the vasomotor functions. Personally, I believe they act in all these ways, but principally in the first two; that is, by peripheral and by central irritations.

In brief, I should express the pathogenesis of gastroenteric auto-intoxication and its consequences somewhat as follows: A strenuous life, either physically or mentally without sufficient daily and yearly relaxation; worry and mental depression, emotional stress and storm, irregularities and excesses which debilitate the nervous system and impair the innervation of the digestive organs; bolting of food, pre-occupation at meals, excess of foods, particularly of animal foods; constipation; imperfect gastric digestion, which throws too much labor on the intestines; achylia gastrica, or marked hypoauidity, which deprives the intestines and their tributary glands of their normal stimulus; infection of the digestive tract from foods, and perhaps from bronchial and nasal catarrhs; irritation and infection of kidneys from ptomaines and bacteria of gastroenteric origin; peripheral irritation of the splanchnic, either chemical or mechanical or both, by putrefying fecal masses, which, combined with irritation of vasomotor centers and perhaps of the heart by ptomaines and toxins, produce arterial hypertension; endarteritis caused by ptomaines and bacteria of intestinal origin, and developing arteriosclerosis; continued hypertension, causing hypertrophy of the heart, and finally dilatation, incompetence, secondary low pressure and death—or continued and perhaps increasing and paroxysmal hypertension with increasing arteriosclerosis, and rupture of cerebral artery, or trophic lesions either of the brain or extremities.

As an instrument of precision, although in a different and restricted field, the sphygmomanometer corresponds to the clinical thermometer. The tactus eruditus of our medical forefathers is a lost art; and even were it not, would be inadequate for the more exact requirements of modern science. And yet our touch should be educated in the fullest sense—not less, but rather more than that of our predecessors—for the extension of our knowledge will be largely nugatory unless it go hand in hand with a perfecting of our means and methods of research. The erudite touch, moreover, while not so exact as the sphygmomanometer, is of much wider and easier application. By touch, then, we should learn to estimate arterial tension—systolic, diastolic and intermediate.

Three methods of palpation are employed:

(1st) Compressing the artery with one finger until the pulse is no longer felt by a second finger placed on the artery just below.

(2nd) Gradually increasing the pressure on the artery with two fingers until the pulse is obliterated, carefully noting pulse changes meanwhile.

(3rd) Placing three fingers on the artery, obliterating the pulse with the lowest one, gradually increasing the pressure with the uppermost until pulse ceases, and with the middle one noting changes in pulse tension, as in the second method.

(To be continued.)

BOARD OF EXAMINERS COMMENDED.

The following letter has been sent to us by the secretary of the Board of Examiners with the request that we publish it. So seldom does one hear anything except the "kicks" of rejected candidates that it is indeed a pleasure to give this word of commendation, publicity:

The California Board of Medical Examiners, San Francisco, Cal. Gentlemen:—I have heard so much about the "unfairness" of the Medical Examining Board of this state that I write to add to your undoubtedly interesting collection.

I received a B. S. from the University of Southern California in 1899, and while there learned to give my papers a fair and correct rating, so when I took my examinations last April I marked my own papers on the slip on which the questions were printed, to compare with what the board considered fair.

	My Marks.	Boards.
Physiology	80	78
Anatomy	82	87
Obstetrics	90	88
Surgery	85	89
Materia Medica and Thera.	70	80
Bacteriology	78	75
Pathology	72	80
Chemistry	65	73
Medicine	75	76

Now, I want to say this: If any two or more men could mark the papers they could not come closer than I did with what marks I received from the board. I gave my marks at the time I handed in my papers, not after I looked them up. And I wish to thank the board for what I considered a "square deal."

I know that this letter is unusual but I simply wanted to say how I was treated and have told many soreheads the same as this.

Thanking you for taking up your time, etc., I am,

Fraternally,
(Signed) RALPH W. AVERY.

Pasadena, California.

Resolutions on Nostrums.

The appended resolution was unanimously adopted by the Germantown Homeopathic Medical Society of Philadelphia at its last meeting and ordered sent to the daily papers and medical journals:

Resolved, That the Germantown Homeopathic Medical Society, of Philadelphia, places itself on record as opposed to the manufacture and sale of all patent medicines or nostrums of whatsoever sort, and requests all members of the medical fraternity to abstain from publishing their articles in any medical journal advertising patent medicines or nostrums.

This Society commends all medical journals and all newspapers which abstain from advertising patent medicines and nostrums for their campaign against the patent medicine and nostrum business.

The pure-food Commissioner of the State is commended for the work he is accomplishing in this direction, and this Society pledges him its support in all future efforts of the same kind.

The public is cautioned against the use of patent medicines and nostrums as unscientific and dangerous to the general health and welfare.

COURSES OFFERED TARRANT COUNTY MEDICAL SOCIETY.

Course 1. Electricity and its Application to Medicine—10 periods—Embracing the theory of electrical energy; demonstrations of positive and negative electricity, detection and different physiological and chemical effects; galvanic batteries and their action; induction and the faradic current; therapeutic uses,

stimulation, diagnosis of degeneration, depilation, cataphoresis, etc.; static machines, methods of examination and demonstrations of diagnostic and therapeutic uses; X-ray burns; medico legal status of skiagraphs, photo therapeutics, etc.

Course 2. Methods of Precision in Clinical Diagnosis—15 periods—Including demonstrations of methods of urinalysis in the detection of pathological chemical constituents, casts, pus and other urinary sediments with exhibition of sections of normal and diseased kidneys; the methods of examining the stomach contents, discussions of diseases of the stomach, exhibitions of pathological specimens and microscopical sections of diseased stomach conditions; demonstration of methods of detecting tubercle bacilli in sputum, urine and exudates by the microscope and animal injection, with exhibition of pathological lungs, dissected subjects and gross specimens and microscopical sections of tubercular organs; methods of detecting the gonococcus, Klebs-Loeffler bacillus, etc.; methods of staining the blood and examination for the malarial plasmodium; hemoglobin estimation and methods of blood counting. This course will be a laboratory course with microscopes and chemical apparatus supplied each physician.

Course 3. Anatomy of the Brain and Cord—12 periods—A dissecting course, each physician to be furnished with an entire brain for dissection; illustrated with drawings, charts and models and by microscopical sections of the various cerebral and cord regions. The course will demonstrate the blood supply, the origin of cranial nerves, the meninges and the superficial anatomy, internal nuclei, ventricles, nerve tracks, etc., accompanied by emphasis on cerebral localization and the relation of the brain to nervous diseases.

Course 4. Bacterial Toxins—12 periods—Covering the history of the germ theory, discussion of decomposition, putrefaction, fermentation and the nature and physiological action of the toxins of eight or ten pathological germs; the germicidal property of blood serum; alexins; precipitins; lysis; agglutinins; including the theory and methods of producing immunity, the preparation and uses of protective serums. The course to include microscopical demonstrations of bacteria to be illustrated by charts and drawings and by animal demonstrations.

Course 5. The History of Medicine—5 periods—To include a study of Egyptian codices, ancient and medieval medicine; the origin of medical terms; historical review of the men whose names are embalmed in medical nomenclature; a discussion of the spelling and pronunciation of medical words and present tendencies in the formation of the newer scientific medical vocabulary.

Course 6. Physical Diagnosis—10 periods—Illustrated by clinical cases, pathological specimens, dissections, charts, drawings and microscopical sections; course to cover the newer methods of detecting pathological conditions of the thoracic viscera.

Course 7. Practical Pathology—15 periods—A laboratory course aided by microscopical work, drawings, charts, animal experimentation and autopsy, showing the nature of pathological processes including inflammations, repair, degeneration, regeneration, hypertrophy, atrophy; the pathology of malignant and benign tumors with special attention to the examination of tissues for malignancy such as uterine curettings, lymph glands, cervical sections, etc.; a pathological study of the principal organs from several selected diseases.

Course 8. Medical Jurisprudence—10 periods—A review of the newer medical jurisprudence in relation to malingerers, legal aspects of pregnancy, birth, legitimacy, abortion, infanticide, impotence, malpractice, insane, X-rays, general principles of toxicology, medical witnesses; expert testimony, autopsies, medico-legal examinations, etc.

Course 9. The relation of man to Animal Life—10 periods—Including a review of the modern conception of the origin of species in the evolution of animal and vegetable forms as demonstrated by comparative osteology, anatomy, embryology, animal distribution and fossil remains; illustrated by comparative skeletons, dissections, embryos, charts and diagrams of the osseous, vascular and cerebral systems of living and extinct forms, and a comparison of the diseases of man and other vertebrates.

Course 10. Technique of Operative Surgery—15 periods—To cover the subjects of sterilization, with plate cultures from hands and ligatures; a discussion of the action of antiseptics; practice in ligature tying; local infiltration methods according to Schleich; skin grafting according to Thiersch; a study of the various forms of sutures; the newer methods of intestinal anastomosis, use of the McGraw elastic ligature, cuff method, Connell suture and Murphy button in enterostomy, with laboratory work on animals.

Course 11. Late Physiological Investigations—10 periods—Illustrated by animal experimentation and diagrams, covering the newer discoveries in physiology, such as heteromorphosis, heliotropism, geotropism and galvanotropism, the production of multiple embryos from one egg, the demonstration of the basis of heredity by cross fertilization of eggs without nuclei, physiological effects of ions, artificial parthenogenesis (artificial fertilization by chemical means, Loeb's methods), the laws of cross fertilization, newer results in cross fertilization in vegetable and animal life, etc.; Mendel's law of heredity and review of experimental proof, etc.

Course 12. Scientific Pharmacology—12 periods—Introduced by modes of drug action, elective affinity, relation between chemical composition and physiological action. A review of Pharmacopoeal preparations and drug classification. Demonstrations of (1) General Remedies: Drugs acting on the nervous system; drugs acting on the heart; drugs effecting cell nutrition. (2) Local Remedies: Drugs having selective action on various organs. Course to consist of lectures and demonstrations of the physiological action of typical drugs in each group on dogs, rabbits and Guinea pigs, aided by physiological apparatus and a review of recent literature.—*Courier-Record of Medicine*.

INSURANCE FEES.

In December we sent a circular letter to every insurance company which, so far as we could learn, was doing business in the state of California. Our letter was in the nature of an inquiry, asking the fees paid for an examination for life insurance, and particularly the minimum fee. To this circular letter we have had replies in all but six instances, and presumably these six pay a fee of \$3, and are ashamed to write and tell us about it. In the case of the newly consolidated Conservative Life and Pacific Mutual companies, making the Pacific Conservative, we have not been informed at the time of writing, what the minimum fee is, if it has been fixed. At least two of the directors of the company, however, have given us personal assurance that they will make every effort to see that a minimum fee of \$5 is paid.

We have reason to believe that several of the companies indicated as paying a minimum fee of \$3, are authorized to pay the \$5 fee if the examiner insists upon it and will not make the examination for less.

At the time that our letter was sent out, the Equitable Life and the Mutual Life paid a minimum fee of \$5; this has quite recently been reduced to \$3.

We would respectfully suggest that you preserve this list carefully and make every effort to divert life insurance from the \$3 companies to the \$5 com-

panies, for the reason that the chances are that the insured will have his policy in a better company if he takes it out in one which pays the medical examiner a decent fee for the work required and thus insures a careful examination by a thoroughly competent man. As we have already pointed out in the columns of the JOURNAL, the \$3 companies, or at least some of them, assume the attitude that if a "physician" will not make an examination for \$3, "some one else" can be found who will do so. A very brief consideration of this attitude will disclose the danger in taking out insurance in such companies.

\$5 Companies.

Aetna Life Ins. Co., Connecticut Mutual Life Ins. Co., Home Life Ins. Co., Manhattan Life Ins. Co., The Mutual Benefit Life Ins. Co., National Life Ins. Co., New England Mutual Life Ins. Co., Northwestern Mutual Life Ins. Co., Phoenix Mutual Life Ins. Co., Provident Life and Trust Co., State Life Ins. Co., Union Mutual Life Ins. Co.

\$3 Companies.

Bankers' Life Assn., The Equitable Life Assurance Co., Fidelity Mut. Life Ins. Co., Metropolitan Life Ins. Co., Minnesota Mutual Life Ins. Co., Mutual Life Ins. Co. of N. Y., N. Y. Life Ins. Co., Penn. Mutual Life Ins. Co., Provident Savings Life Assurance Co., Travelers' Ins. Co., Union Central Life Ins. Co., Washington Life Ins. Co.

No Reply to Letter.

Germania Life Ins. Co., Hartford Life Ins. Co., Life Assn. of America, Massachusetts Mutual Life Ins. Co., Mutual Reserve Life Ins. Co., Netherlands Life Ins. Co.

Encouraging.

Very few of the important newspapers have taken an open part in the nostrum fight. The San Francisco *Chronicle*, which, ever since the plague days of San Francisco, has been an anti-public-health organ, gives the nostrums editorial support. The Brooklyn *Citizen* and the Houston *Post* print as their own views matter sent to them by the Proprietary Association; but mostly the nostrums must depend for backing upon compliant second and third rate journals like the Youngstown *Telegram*, the Bangor *Commercial*, the Dayton *Herald*, the Dayton *Journal*, the Riverside (Cal.) *Enterprise*, and that ilk. Although they profit largely by patent medicine advertising, the Philadelphia *North American* and the New York *Sun*, to take two conspicuous examples, have not hesitated to print news matter of the kind which the Proprietary Association regards as "destructive," and even the New York *World*, which carries more medical advertising than any paper in the country, has thus far denied its news and editorial columns to these liberal purchasers of advertising space. On the whole, we think the Proprietary Association has a right to be disappointed in the newspapers. It hasn't been getting what it thought it was paying for.—*Collier's Weekly*.

For the control of nasal hemorrhage tampons can be readily prepared as follows: A layer of cotton is wound around a penholder or similar object until the desired thickness is obtained and then withdrawn. The cotton cylinder is then moistened, squeezed dry and inserted into the nasal cavity. If the projecting end of the tampon is now moistened it will swell up and thus produce sufficient compression.—*International Journal of Surgery*.

STRONGEST IN THE WORLD
THE EQUITABLE LIFE ASSURANCE SOCIETY
OF THE UNITED STATES,

No. 120 BROADWAY, NEW YORK

MEDICAL DEPARTMENT.

WILLIAM R. BROSS, M. D., MEDICAL DIRECTORS. ARTHUR PELL, M. D.,
JOHN WARREN, M. D., T. H. ROCKWELL, M. D., F. C. WELLS, M. D.,
ASSISTANT MEDICAL DIRECTORS

NEW YORK February 15, 1906.

Dear Sir:--

By order of the President, we advise you that on and after March 1st, 1906, the fees for medical examinations allowed by the Equitable Life Assurance Society throughout the United States and Canada will be as follows:

- \$3.00 for each examination where the amount applied for is \$3,000 or less.
- \$5.00 for each examination where the amount applied for is over \$3,000 and less than \$25,000.
- \$7.50 for each examination where the amount applied for is \$25,000 or over, and less than \$50,000.
- \$10.00 for each examination where the amount applied for is \$50,000 or over.

(An extra allowance of \$1.00 will be made when an additional specimen of urine is obtained by order of the Society.)

The loading for expenses in connection with our business is a percentage of the premium, and the uniform fee heretofore paid has made the expense of procuring a small policy too large, whereas a larger fee can properly be paid in connection with the larger policies.

We do not wish to be understood as assuming that it is less work to examine a risk for \$1,000 than one for \$5,000, but the Society can properly pay more for examining a \$5,000 risk than it can for the smaller amount.

We trust that the foregoing schedule will be satisfactory to you, and will thank you to fill up, sign and return to us at once the enclosed postal.

Very truly yours,

MEDICAL DIRECTORS.

The Equitable Life Assurance Society.

Philanthropic Physicians.

In order that we may aid the Equitable Life Assurance Society to disseminate amongst the physicians of this coast its insulting information in regard to insurance examinations, we have taken the liberty of reproducing the circular letter which this concern is sending out and present it to you herewith for your consideration.

Several things about it are of interest. In the first place, we note that the reduction in fees for life insurance is made "by order of the president." The "president" is a gentleman by the name of Paul Morton, who, during his connection with the Santa Fe Railroad Company, entered into certain illegal contracts regarding rebates, etc., for which he was only saved from criminal prosecution subsequently by the kindly intervention of Mr. Roosevelt. Unfortunately, at the time that the rebate matter came

out, Mr. Morton was a member of Mr. Roosevelt's cabinet.

We understand that he is endeavoring to struggle along on the pitiful salary of \$60,000 a year (or is it \$80,000?), and in his distress we certainly extend our sympathy. Doubtless it is for the reason that he is forced to live on such a small income that he now asks the physicians of the country to get along with somewhat less and thus endeavor to reimburse the company for its loss due to the vast sums which have been stolen from the policy holders by the officials who in the past have had charge of the company.

Are you going to contribute to this fund? Or are you going to advise the Equitable Life Assurance Society that you have too much self-respect to accept this reduction in compensation?

MEMBERS AND EX-MEMBERS OF THE PROPRIETARY ASSOCIATION OF AMERICA.

Below is a list of the twenty-seven firms who were written to in December, by the Publication Committee of the State Society. Their names had appeared in the list of members of the Proprietary Association of America, published by the *Journal A. M. A.*, and they were requested to set forth an explanation of their somewhat equivocal position, for it is now pretty generally recognized that the Proprietary Association is strenuously fighting the efforts to remedy the nostrum evil, of the American Medical Association.

Unfortunately, the entire correspondence is too voluminous to publish. Some of it would undoubtedly be of considerable interest to our members, and some of it would probably be found very amusing. One or two firms seemed to resent our respectful inquiry as impertinent. Why, forsooth, should the humble and groveling physician dare to ask impertinent questions as to the business methods of his owner? All that is necessary for the physician to do, is to go right ahead and mind his business and believe what he is told. Questions are impertinent!

We take pleasure in announcing that the following firms have signified their resignation from the Proprietary Association of America: Fairchild Bros. & Foster, N. Y.; the Fellows Mfg. Co., 26 Christopher st., N. Y.; E. Fougere & Co., 26 N. William st., N. Y.; Kress & Owen Co., 210 Fulton st., N. Y.; The Fraser Tablet Co., N. Y.; Mariani & Co., 52 W. 15th st., N. Y.; The Purdue Frederick Co., 298 Broadway, N. Y.; Schieffelin & Co., 170 William st., N. Y.; Geo. C. Fry, Portland, Me.; Horlick's Food Co., Racine, Wis.; Johnson & Johnson, New Brunswick, N. J.; Keasbey & Mattison Co., Ambler, Pa.; Lambert Pharmacal Co., St. Louis, Mo.; Mellier Drug Co., St. Louis, Mo.; Mellins Food Co. of N. Am., Boston, Mass.; Micajah & Co., Warren, Pa.; Schlottbeck & Foss Co., Portland, Me.; Smith, Kline & French Co., Philadelphia, Pa.; The H. K. Wampole & Co., Philadelphia, Pa.; The Alkalol Co., Taunton, Mass.

The following firms have advised us that they still retain membership in the Proprietary Association, so we may regard them as endeavoring to controvert the efforts of the medical profession to put a stop to the fraudulent nostrum business: The Chas. N. Crittenton Co., 115 Fulton st., N. Y.; Seabury & Johnson, N. Y.; The Cystogen Chem. Co., St. Louis, Mo.

The following have not considered it necessary to do us the courtesy to reply: Geo. J. Wallau, 2 and 4 Stone st., N. Y.; Arthur Peter & Co., Louisville, Ky.; Katharmon Chem. Co., St. Louis, Mo.; The Wyttenback Chem. Co., Evansville, Ind.

THOMAS KELLEY, M. D.

In Memoriam.

On Wednesday, the fourteenth day of February, at his home in San Jose, our colleague Doctor Thomas Kelley passed to his rest after having almost reached the allotted span of "three score years and ten."

To those of his intimate professional brethren his sudden taking off, while it came with shock, occasioned no surprise. To the trials, hardships and exposures he endured in the service of his country we may attribute the remote cause of that disease which parted him from us in the midst of his usefulness.

In life Doctor Kelley was no ordinary man: no common-place physician. In both it was given him to excel. We may leave it to his former comrades in arms to extol his patriotism, to tell again of his

virtues as a soldier and recount his deeds of valor while we speak of him as he abode with us.

Doctor Kelley received his degree of "Doctor in Medicine" from Rush Medical College of Illinois on the first day of February in the year 1871. Coming to California in 1876 he began practice in this community and at once established a reputation for learning and skill in his profession. He was one of the original members of this medical society in 1876, and served it faithfully in all capacities and as an honored president. Much is due to his efforts for the present existence of our medical practice law. At our meetings and social gatherings he was ever present until a few years ago when the malady from which he suffered became so marked that his further regular attendance was rendered impossible. Nevertheless his continued interest in our work was always manifest. Doctor Kelley was a gentleman of the highest type of manhood at all times and in all places. He was one of those in our profession who pursued a strictly ethical course of conduct in his relations to other physicians and to the many of the laity he was called to serve. As a physician and surgeon his great ability and ripe experience were eagerly sought in our counsels. His life was pure, unselfish and generous. Although he endeavored to conceal his gifts he was noted for his professional charities to the poor and destitute. To his host of friends he was loyal. To his family he showed his loving character and left no care undone which would add to its comfort and happiness.

In this memorial hour may each of us resolve to cherish all the good and noble of which we knew him to be possessed. May we strive to practice more and more those precepts of uprightness in our own professional lines of which his life was a daily example. Out of the abundant love in our hearts for the father let us extend to the children our deep sympathy for their loss and may the memories of his goodness and greatness solace them in their grief and lighten the night of gloom, and as a token of our esteem as well as of our own sorrow let this tribute to his many virtues be inscribed on a memorial page in our records of this society.

The above Memorial, written by the president of the Santa Clara County Medical Society and presented by the first vice-president, Doctors J. L. Asay and I. N. Frasse, respectively, was unanimously adopted by said society at a regular session held February 21, 1906, and it was further ordered that a copy of the same be spread upon the records of the society and copies be forwarded to the family of the deceased colleague and to the STATE MEDICAL JOURNAL.

Explain to your friends and patients that practically every newspaper in the United States is a silent partner in the nostrum fraud business. That it is bound to silence and to aid in defrauding the people into using alcoholic nostrums by the following clauses in its advertising contracts with the nostrum trust:

1st. It is agreed in case any law or laws are enacted, either State or National, harmful to the interests of the (Nostrum Manufacturing Co.), that this contract may be cancelled by them from date of such enactment, and the insertions paid for pro rata with the contract price.

2d. It is agreed that the (Nostrum Manufacturing Co.) may cancel this contract pro rata in case advertisements are published in this paper, in which their products are offered, with a view to substitution or other harmful motive; also, in case any matter otherwise detrimental to the (Nostrum Manufacturing Co.'s) interests is permitted to appear in the reading columns or elsewhere in this paper.

(See *Collier's Weekly*, Nov. 4, 1905.)

COUNTY SOCIETIES.

Santa Cruz County.

The regular meeting for the month of March was held on the 12th with an excellent attendance. Dr. Chas. Anderson resigned as secretary and Dr. H. E. Piper was elected to fill the unexpired term. Three new members were elected—Drs. Piper of Santa Cruz, Briggs of Watsonville and Burbank of Corralitos.

The following clinical cases were brought up and discussed by the society: One, "Sarcoma of the Bladder"; two, "Diabetes"; three, "Menorrhagia"; four, "Posterior Urethritis" in patient sixty years of age.

Contra Costa County.

The Contra Costa County Medical Society met in the office of Dr. George at Antioch, February 25, 1906, with Dr. C. L. Abbott in the chair.

The following were present: Drs. Abbott, Mead, Barney, F. Rattan, Blake, J. W. Key, Brown, Hammond, Lucas, George, Martin and DeWitt.

The following motions were passed:

That meetings of this society be held on the last Sunday of each month.

That a committee of three be appointed to formulate a new set of by-laws that will be in harmony with the State Society. The following were appointed on the committee: Drs. Rattan, George and DeWitt.

That the secretary be instructed to purchase a duplicator.

J. WALTER KEY, Secretary.

Tulare County.

In response to a call from the Secretary of the State Society, a meeting of the physicians of Tulare county was held at the Palace Hotel in Visalia on February 16th. A good attendance was present and the general purposes and outline of the present organization movement were thoroughly discussed, after which it was unanimously decided to organize the Tulare County Medical Society.

Organization was immediately effected and the following officers elected: President, Dr. W. W. Cross of Visalia; vice-president, Dr. J. B. Rosson of Tulare; secretary, Dr. M. L. Pettit of Visalia; delegate to the State Society, Dr. R. E. Bering of Tulare.

It is gratifying to know that meetings of this society are to be held every two weeks and that a systematic scientific work is to be undertaken by the society.

San Joaquin County.

The regular monthly meeting of the San Joaquin Medical Society was held February 23rd at the office of Dr. Ira B. Ladd. Dr. Chas. R. Harry in the chair. The following members were present: Drs. R. B. Knight, W. J. Young, J. P. Hull, W. W. Fitzgerald, W. S. Snedigar, Ira B. Ladd, C. R. Harry and B. J. Powell; Drs. E. L. Blackmun and Hudson Smyth as guests.

It was decided that a committee of three, consisting of Drs. Hull, Young and Ladd be appointed to revise the fee bill of the San Joaquin County Medical Society and to report at the next regular meeting; after the acceptance of the same that each member be required to sign his name endorsing such fee bill. Drs. E. L. Blackmun of Stockton, J. Audley Young and J. Goodwin Thompson of Oakdale were elected members of our society.

Dr. Ladd first presented for the consideration of the members present a case of leukoderma with exophthalmus. The subject of his paper was a report of a case of large cystic degeneration of the kidneys. The diagnosis, as the doctor proved by the authorities

presented, was made in the usual way, at the post-mortem. Both kidneys were presented for the inspection of the members. The discussion was opened by Dr. Fitzgerald and followed by the members and guests present.

BARTON J. POWELL, Secretary.

Orange County.

The Orange County Medical Association met in regular session at the residence of Dr. Freeman in Fullerton, March 6th. There was a good attendance of members and three visitors. Acting on the suggestion of Dr. Jones during his visit recently the society decided to organize clinical clubs as auxiliary to the county society. For the present it was thought best to organize two only, one for Anaheim, Fullerton and vicinity, and one for Santa Ana, Orange and vicinity.

Letters were presented from different insurance organizations notifying their examining physicians of a reduction of fees. The society unanimously voted in favor of a resolution to maintain a \$5.00 rate for all old line companies; also making it an offense for any member to accept appointment where the former examiner had been dismissed on account of the reduced fees.

Dr. Chas. C. Browning read a very interesting paper on the "Early Diagnosis of Tuberculosis," maintaining that the diagnosis should be made from the symptoms and physical signs before it is possible to find the tubercle bacilla in the sputa.

After adjournment, Dr. and Mrs. Freeman served a delightful repast and all went away feeling it was good to be there.

H. S. GORDON, Secretary.

Ventura County.

At the Rose Hotel, Ventura, Monday evening, February 26th, a meeting of the Ventura County Medical Society was held.

Dr. P. M. Jones, secretary of the Medical Society of the state of California, San Francisco, was the guest of the society and the orator of the occasion.

He told his hearers of the earnest work being done everywhere, especially in California, by the medical profession, in warning the public of the very grave dangers of the use of advertised nostrums, manufactured by ignorant pretenders having no knowledge of medicine, and the use of which has certainly caused many sudden deaths, occurring daily, and with increasing frequency, and physicians could not be too emphatic in their condemnation. Dr. Jones referred with great satisfaction to the great work for humanity accomplished by that great journal, *Collier's Weekly*, in exposing the patent medicine trust, as well as the rottenness of so many newspapers, and high public officials as well.

It was the duty of physicians to be active in the discharge of their civic obligations, to further the enactment of laws best calculated to preserve health and prolong human life.

The meeting was well attended, and was followed by a banquet, which was enjoyed by all.

At the conclusion, the society gave a vote of thanks to Dr. Jones for his masterly address.

CHARLES TEUBNER, Secretary.

San Bernardino County.

The regular monthly meeting of the San Bernardino County Medical Society was held in the Y. M. C. A. parlor, Redlands, February 14th. The president, Dr. Blythe, called the meeting to order at 2 P.M., with the following members present: Drs. Abbott, Champion, Hurley, Thompson, Bennett, Blythe, Shreck, Pound, Burke, Taltavall, Moseley, Ide, Evans, Hutchison and Strong.

Dr. E. W. Burke of Highland, and H. F. Andrews of San Bernardino were elected members of the society. The application of Dr. Osborne was received

and referred to the Board of Censors, to be acted upon at the next meeting. A letter was read from the secretary of the Santa Barbara County Medical Society giving a brief outline of their method of conducting the society and asking for suggestions.

After other routine business was disposed of Dr. Champion read a very interesting and instructive paper on "The Mayo Clinics." Dr. Abbott followed with a very valuable paper on "Diet in Disease."

Dr. Moseley made a motion that hereafter all papers read before the society become the property of the society and that they be published at the direction of the society.

The meeting then adjourned to meet in Colton March 14th and decided to invite the members of the Riverside County Society to meet with us at that time.

D. C. STRONG, Secretary.

Humboldt County.

At the January meeting of the Humboldt County Medical Society the following officers were elected: President, George N. Drysdale; vice-president, H. G. Gross; treasurer, C. O. Falk; secretary, J. H. Mallery; delegate, Geo. W. McKinnon; alternates, R. E. McKibbin, J. S. Menefee.

The following committees were appointed: Program and Scientific Work, Drs. Mallery, Felt and Mills; Legislation and Public Health, Drs. C. C. Falk, Sinclair and Hill; Entertainment, Drs. Dorais, Marshall and Thompson.

The following letter was adopted and sent to all druggists in the county:

To the Druggists of Humboldt County.

Gentlemen: Realizing the enormity of the patent medicine evil, in all its phases, and fully appreciating the immense power which the retail drug trade may yield in this connection, the Humboldt County Medical Society begs leave to address you. We would ask that in order to overcome this great evil, to stop, if possible, the wholesale formation of chronic alcoholics and drug tipplers, the retail druggists of this county set the example to the state at large by discouraging to the greatest possible extent the sale of all patent or secret medicines, offering for sale instead preparations of their own manufacture, of known formula and merit. In return the members of this society agree to adhere as much as possible to the preparations official in the United States Pharmacopeia in prescribing and to discourage to the fullest extent the use of all secret nostrums prepared for prescription use.

We as physicians wish to see this great evil stopped. It works great injury to both of our professions, but the public suffers most of all. We ask you to work with us in this matter, that it may be said that in Humboldt county the pharmacists and physicians are standing together and working hand in hand for the general good.

Hoping for your co-operation, and looking toward a closer union between the two professions, we are,

Yours sincerely,

Humboldt County Medical Society.

J. H. MALLERY, Secretary.

Santa Barbara County.

The Santa Barbara County Medical Society held its regular monthly meeting on February 12, 1906, at the Arlington Hotel, adjourning to Dr. Conrad's office. Present, the regular members; visitors, Drs. J. Ewing Mears of Philadelphia, and William Thomas Corbett of Cleveland. The meeting was called to order by the president, Dr. W. B. Cunnane. Reading of minutes of last session. The retiring president, Dr. Flint, spoke briefly, urging the society to advance along certain proper and needful lines. The newly elected president, Dr. Cunnane, followed with an interesting address. He said in part that he was

a believer in sectional work—and to this end would appoint chairmen of different sections in medicine and surgery. He urged that every gentleman connected with the organization contribute his part toward making it a professional, social and intellectual success, and in order to accomplish this we must lay aside our personal prejudices and petty jealousies. With harmony and unity as our watchword success is assured. The Society next listened to a fine paper by Dr. J. Ewing Mears from Philadelphia, Prof. Surgery (Emeritus) Jefferson Medical College. The title of Dr. Mears' paper was "Reminiscences in Surgery." The Doctor touched upon the introduction of anesthesia in the United States, the entrance of aseptic and antiseptic methods; and his meeting Lord Lister in Philadelphia in 1876. Dr. C. S. Stoddard of Santa Barbara, followed Dr. Mears with an able and practical paper on "Existing Relations Between Physicians and Druggists." The Doctor so forcibly brought out the disgraceful and baneful condition of counter prescribing prescription repeating and other unethical methods of many pharmacists, as to rouse the Society to a warm and animated state of indignation. Much discussion followed ending with the unanimous passing of a suitable resolution looking to the correction of such abuses. The subject of Physicians' fees on program was only partially discussed owing to the absence of Dr. Anderson. The question of receiving into Society any legally qualified physician regardless of school practice was forcibly acted upon, and the President then announced the various sections for scientific work, and the meeting adjourned to meet March 12, 1906.

WILLIAM T. BARRY, Secretary.

San Benito County.

The San Benito County Medical Society met at the residence of Dr. J. H. Tebbetts on February 22nd, with the president in the chair.

Dr. R. G. Curtis, formerly of the Hawaiian Territory, made application for membership and was duly elected. An amendment of the by-laws was introduced by the secretary as follows:

Resolved, That Section 2, Chapter II, of the by-laws be amended to read, "A meeting shall be held at 8 P. M., on the first and third Thursday of each month." This was unanimously adopted.

The next order of business being the election of officers, Dr. F. O. Nash was elected president, Dr. J. D. Ball, vice-president; Dr. J. M. O'Donnell, secretary; Dr. R. G. Curtis, treasurer. Dr. J. M. O'Donnell was elected censor for one year and Dr. L. C. Hull for three years.

Contract lodge work was discussed in detail by all present, and a committee was appointed to draft resolutions abolishing such work and to report at the next meeting. Drs. F. O. Nash, J. H. Tebbetts and R. G. Curtis were appointed such committee. The society then adjourned to meet March 1st at the residence of R. G. Curtis, the president in the chair.

After the call to order the following resolutions were read and unanimously adopted:

Whereas, It is a well-known fact that the practice of medicine under the conditions that prevail in so-called lodge practice is injurious to our profession, both as a whole and as to individual members, be it therefore resolved by the San Benito County Medical Society that it is the sense of this society that members decline all appointments to lodge or similar society practice; be it also further resolved that any member now holding such contract relations resign such appointment upon the expiration of his present term.

A motion to amend the fee bill was then introduced as follows:

Resolved, That a sum of not less than \$5.00 be the minimum fee for life insurance examinations and not less than \$3.00 for fraternal insurance associations, and that mileage of \$1.00 one way for each mile

over three miles from town be added on such insurance examinations.

Dr. L. C. Hull was elected as delegate to the annual meeting of the State Society and Dr. J. H. Tebbetts as alternate.

J. M. O'DONNELL, Secretary.

Riverside County.

One of the most interesting and best attended meetings of the Riverside County Medical Society was held on the evening of February 12th at the home of Dr. W. B. Sawyer.

Our new president, Dr. Martin, occupied the chair and called the meeting to order. After reading of the minutes and communications, the report of the auditing committee for the past year was read and accepted. Considerable discussion followed concerning examinations for life insurance. A certain company claiming to write cheap insurance with a small weekly payment and asking only a perfunctory report on the general state of health, for which it could not pay more than 50 cents, had requested some of our members to examine for them. On Dr. Sawyer's motion the society resolved that as far as this society is concerned such examinations are on a par with all others and shall be held to the minimum fee of two dollars.

City Health Officer Roblee asked the co-operation of the members in making his monthly reports to the State Board.

As a result of the success of the semi-social features of our meetings, which have been held at the homes of the members for the past three years and have ended in banquets, it is no surprise that we feel a longing for more frequent meetings. After discussion of some of the plans recently published in the STATE and A. M. A. journals, a committee was appointed to work out a plan for weekly or bi-weekly meetings which shall take on more of the nature of study classes. We hope to have a continuous post-graduate work going on all the time.

The first paper of the evening was by Dr. Parker on the subject "Burns—Skin Grafting." After speaking of the desirability of maintaining asepsis in these wounds, and deploring the fact that so often in our anxiety to relieve the sufferings of our patients at once we rush on most anything which is convenient, he told us of the success which he had enjoyed with the use of a simple steril "salt solution" dressing. He simply saturates gauze with this solution and covers it with a mass of dressing and bandage, and then has the nurse keep this dressing moist with the solution by pouring it onto the dressing from time to time. This he thinks will answer fully as well as the picric acid dressing which leaves such a disagreeable stain upon everything with which it comes in contact.

He described the different methods of skin grafting, speaking with great satisfaction of the use of Cargile membrane as a covering of the Theirsch grafts.

A very animated discussion followed which brought out many interesting experiences.

Then being the time for refreshments, we repaired to the dining-room where we all did full justice to the elegant repast tendered by Mrs. Sawyer.

Upon reconvening we listened to a paper by Dr. Griffith on "A Case of Abdominal Tumor," which proved upon removal to be a cyst of the lesser omentum. He described well under what difficulties good work can be done. This patient was operated upon in a private house out on the Imperial desert, and made a very satisfactory recovery.

As further evidence that a kindly brotherly feeling had been instilled into the company by the social amenities of the occasion, it was resolved to have a regular banquet at the Victoria Club at the next meeting, and a committee was appointed to execute plans for the same.

C. VAN ZWALENBURG, Secretary.

Placer County.

The Placer County Medical Society met in Colfax, March 3d.

Dr. Peers read a very able paper on "The Prophylaxis of Tuberculosis." In brief the paper covered the hygiene of everyone, especially those predisposed to tuberculosis; this applied to both house hygiene and to food hygiene. Every public room or building should be supplied with wide-mouthed spittoons which should be filled with some antiseptic, but patients suffering from tuberculosis should be warned not to use these, but each should carry in his pocket a flask made for the purpose. If the patients are confined, spit-cups of the usual pattern may be used. Toilet paper or even Japanese napkins are excellent as they can be burned immediately after use. In coughing a handkerchief or at least the hand should be held before the mouth and the hand should be thoroughly disinfected afterward. All house linen is to be sterilized frequently and the hands must be washed before eating. Masks should be worn over the mouth saturated with some mild antiseptic, the patient being told that the inhalation of the drug is beneficial, the real object being to protect others from the invisible sputum.

Legislative measures must be advocated, registration of all consumptives is necessary and the patient's family given printed instructions. One most important point that the doctor emphasized was the following:

"In Colfax one sees consumptives from all over the states. Of patients who have consulted specialists in the East, hardly one is told not to swallow his sputum; this I consider to be one of the most important points in the prophylaxis of the consumptive."

The doctor had some drawings made of various receptacles for sputum. An animated discussion followed the reading of the paper.

Dr. White of Auburn read an excellent paper on "Autointoxication," the subject was taken in its various phases and the treatment of each was proposed; dieting, intestinal antiseptics, and colon irrigating were advocated for this trouble when caused by intestinal fermentation.

Dr. Fay presented his "Experience and Conclusions in Handling Quinsy." In reviewing the treatment of this trouble during the last century Dr. Fay has arrived at the conclusion that to-day we are no nearer helping the patient than they were in 1800. The contents of the Pharmacopeia are useless and very rarely can one reach the abscess with the knife; all that one can do is to make the patient as comfortable as possible and wait for the pus to evacuate itself. The salicylates have not proved very much good in his hands.

Dr. Jones said that he had always looked on quinsy as a purely surgical disease and had treated it as such.

The various members present also gave their experiences with this very troublesome disease.

Dr. Schnabel of Newcastle presented two pathological specimens and demonstrated the use of a pair of hysterectomy forceps that he had had made in Germany and that he had found more suited to his purpose than the ones usually sold in the instrument stores. He also demonstrated a pair of self-retaining retractors that he had constructed out of steel bicycle wire and that he had found very useful in emergency work.

Dr. Peers entertained the society and provided a banquet for which a vote of thanks was passed. The evening in every way was a great success.

The next meeting of the Placer County Medical Society will be held at Rocklin, Placer county, on the afternoon of April 28th. Dr. Henderson of Sacramento has kindly consented to read a paper at that meeting.

J. H. MULES, Secretary

Santa Clara County.

The regular meeting of the society for February was held on the 21st in the parlors of the St. James Hotel, San Jose. The following attendance was noted: Doctors Wright, Harris, Marvin, Fraser, Burns, Jordan, Witter, Grissim, Frasse, Paterson, Wagner, Simpson, Cothran, Paul, McMahon, Newell, Osborne and Asay in the chair.

The following were elected to membership: Dr. E. A. Kelley, Agnews; Drs. Caroline L. Avery, Wm. E. Keith, John McMahon, Chas. A. Wayland, Edna M. Greenwood, L. T. Brock, S. B. Lyon, Ed. Ulrich, San Jose; Dr. Clara A. Silvia, Gilroy.

Dr. Frasse, first vice-president and chairman of special committee on membership made the following report:

"Mr. President and Gentlemen:—Your committee on membership has met on several occasions and concurred in the drafting of a circular letter, appended, of which a copy has been sent to every physician of the county whom it was considered desirable to secure as a member.

"Dear Doctor:—It is well known to you as to all of us that the medical profession of Santa Clara County has been for many years divided into many factions. There is room in the County Medical Society for any school or system of medicine if practiced honestly by a qualified physician and we, the membership committee of that society, unite in urging you, as an honest and qualified physician, to join the society.

"Because the profession will accomplish more if it is a unit.

"Because we want your council and advice.

"Because with a united body it means the practice of Santa Clara county for Santa Clara county practitioners.

"Because we want you to unite with us in fixing a reasonable Fee Bill which you and all of us can and will maintain.

"Because we believe your interests are ours and ours are yours.

"Personal differences with any member should not keep any one out of the society. You will call into consultation only those with whom you are friendly and your influence in the society may be just what is needed to change the methods of the member with whom you differ.

"A unanimous personnel of the county society is desirable that we may be in line with the recent organization of the profession as laid down by the American Medical Association and which is being adopted all over the state. Such a unit may more effectually combat the many and various evils that now harass and threaten us and act as detriments to the public at large, and so that petitions sent to our legislative bodies regarding measures necessary to our welfare may represent the opinion of a body of men whose desires are to be respected.

"It is the desire of the executive committee to make the meetings of the society the equivalent of a post graduate school; to be addressed at times by the leading men of the state upon topics upon which they may be considered authorities, and most of all to engender a spirit of good-fellowship among us, such as should exist among members of our profession. The yearly dues are five dollars which covers membership fees in the county and state societies and eligibility to membership in the American Medical Association. It also includes the subscription price of the STATE JOURNAL OF MEDICINE, issued monthly (a high class journal *not dominated by any drug firm*), and the Register and Directory of Physicians and Surgeons of the state of California, Oregon and Washington.

"Application for membership may be sent to any

member of the committee or to any officer of the society.

"(Signed)

IRWIN N. FRASSE, M. D.
LINCOLN COTHRAN, M. D.
J. F. BURNS, M. D.
WILLIAM SIMPSON, M. D.
W. W. FRASER, M. D.
J. D. GRISSIM, M. D.

"Your committee is now engaged with the kind assistance of our president, in numbers of two or three, in making personal visits upon the various physicians about town.

"Respectfully submitted, etc."

The president announced the death of Dr. Thos. Kelley of San Jose, a member of this society since its organization, and reported the action taken in having the society represented at his funeral. An eloquent memorial prepared by Dr. Asay and presented by Dr. Frasse was adopted and ordered spread upon a memorial page of the records of the society, copies of the same to be prepared and forwarded to the family of our deceased colleague and to the STATE JOURNAL OF MEDICINE.

The secretary called attention to the 30th anniversary of the organization of the society and suggested that the executive committee take up the matter of arranging for a banquet in the near future preparatory to a fitting celebration of the event. So ordered.

Dr. Lincoln Cothran presented a paper entitled "Some comments on the workings of the Medical Practice Act." The paper was a vigorous defense of the Act, and sustaining the Board of Medical Examiners in their efforts to keep high the standard of examinations and to exclude incompetent and insufficiently qualified practitioners. The subject and the paper were discussed by Doctors McMahon, Newell, Paterson, Jordan, Wright, Marvin, Burns Osborne and the president.

The proposed new constitution and by-laws was ordered the special order for business for next meeting and Dr. Jordan gave notice that the executive committee had arranged a Symposium on Eye and Ear work for the scientific program for next meeting, to be presented by Doctors Wagner, Simpson, Smith and Jordan.

The meeting of the society for March will be held at the St. James Hotel, San Jose, on Wednesday evening, the 21st instant, at the hour of seven o'clock. As matters of unusual importance will be presented a full attendance is requested.

A. E. OSBORNE, Secretary.

San Francisco County.

The meeting on the 13th of February was called to order at 8:45 P. M., Vice-president Gibbons in the chair, the president being detained at the directors' meeting. Later in the evening the president took the chair.

The following was the program of the evening:

"The Role of Hydrotherapy in Chronic Diseases"—Dr. Simon Baruch, of New York.

"The Dietetic and Physical Treatment of Cardiac Dropsy"—Dr. A. Perry.

The Committee on Admissions reported the following men elected members of the society: Drs. Chas. H. Whitman, John C. Newton and Howard Somers. The president announced them duly elected members.

The following applications for membership were read: Drs. W. B. Kearney, Alvin E. Cerf, Richard Dowdall, W. E. Rumwell, Harry Horn, David Stafford.

The meeting adjourned at 10:30 P. M.

Dr. Sampson, discussing the paper read by Dr. Baruch: I am very much interested in this subject, especially with its use in bronchial diseases. This use of cold water in most bronchial diseases is a most efficient remedy. The system can be put into shape

and the patient can be cured. The methods which the doctor has used and the precision which is emphasized are the means by which good results can be obtained. Sciatica is a good illustration of the sort of disease which can be treated. Of course, there is no certain line of treatment to be used for all patients. In hydrotherapy you have to study your patient. There is no remedy which requires so much observation and careful application of the treatment to each individual patient. Not only a recognition of the special diseases but all conditions of the patient have to be taken into consideration. Recently I treated a patient with asthma and bronchitis. In using the cold treatment I found out that I could not get any reaction; every application simply made the patient colder. It is very interesting to watch the result that can be brought about by a graduated process of increasing the applications. Using the hot water first then gradually colder. In three weeks the patient could stand any amount of cold water and the asthma and bronchitis entirely disappeared. The reaction was most positive. I wish to emphasize the necessity of the study of the patient and careful application and outlining the routine treatment and carrying it out in detail. Good results can be brought about in nearly all chronic cases.

Dr. Parsegian: I think that hydrotherapy can be used for many purposes. As the doctor mentioned, it is like a drug. One can bring on stimulation, a sedative effect, etc., as indicated. Duration of the treatments is an important factor. We see that the result obtained in the asthma case, of which the doctor has just spoken, was due to a peculiarity of the nervous system. The shock in most cases is one of the most beneficial things.

Dr. Rosenstirn: There is one thing in the very able paper of Dr. Baruch that I would like to have had him talk more about, and try to institute in all cities. That is the institution of a corps of regularly schooled nurses to apply the hydrotherapy methods. Our patients, unfortunately, are not rich and many do not go to hospitals. These matters can only be done by a well educated, trained person. We put our patients at their homes in the hands of their friends or relations who are easily tired of doing the things mapped out, especially the necessary details in the exercise of hydrotherapy methods. As we have not a regular school corps of nurses conversant with these methods, I think one of the necessary and very urgent applications of hydrotherapy methods cannot be fulfilled. I would like the doctor to exercise his energy in that direction. Nurses should know the applications and doctors should be able to simply write prescriptions as for medicines to do the drip sheet method, the wet cloth method or whatever is necessary, and save him the time of explaining it all each time. That is just why hydrotherapy has not been taken up. It takes too much time and has not been made easy for the doctors.

Dr. Evans: This is a subject in which I am very much interested, having seen Dr. Baruch in New York and having followed out a certain amount of hydrotherapy in my practice. I would add a suggestion to Dr. Rosenstirn's talk, that a movement be put on foot for introducing into our medical schools, if necessary, chairs in hydrotherapy, so it can be taught to our medical students. Those in hospital service are impressed by the fact that our internes come from these medical colleges with very hazy ideas about the action of water.

Dr. Power: The remarks made by Dr. Evans are quite true. We do need that this method should be taught. The use of hydrotherapy would be more general if more knew about it. The great difficulty in introducing it into the colleges is the time it would take. We are all short of time in nearly all the medical schools in the United States. If another chair is added to the course, it would be impossible to carry it out. We need, and should have, if not a full chair, some instruction, if only a few lectures.

Dr. Baruch: I have nothing much to say as the opinion seems to be quite in the line of my own recommendations. There is only one especial point that is not quite appreciated, perhaps, as I stated it. With regard to the training of nurses, that I have spoken of in my paper. With regard to taking it up in the colleges, it would not require a chair on hydrotherapy, merely a few lectures, perhaps half a dozen, with clinical demonstration. The student will never learn unless he handles it himself. I teach them thus at home, and there are always one or two technical points to be brought out and the class appreciates it when I make the men do it over and over again. Anyone can read a book on hydrotherapy and follow it. Some ten years ago Thomas suggested that a chair be put in the college at home, and they claimed they were overcrowded as it was. About two months ago Lambert found that the curriculum was not overcrowded and he aroused them to the fact that it was better to teach hydrotherapy.

Meeting of the Directors of the County Medical Society.

Meeting called to order at 8:20 P. M., February 13, 1906, President Terry in the chair.

Those present were: Drs. W. I. Terry, D'Arcy Power, J. H. Barbat, P. K. Brown, C. M. Cooper, D. Tait, W. S. Thorne, F. B. Carpenter, Wm. Ophuls, Geo. Blumer, Henry Gibbons, Jr., H. Morrow, C. Levi-son, H. M. Sherman, P. M. Jones, Geo. Evans.

The minutes of the last two meetings read and approved.

Dr. D'A. Power presented a report of the Committee on Ethics. It was moved that the report be received and placed on file. Motion carried.

Dr. P. M. Jones reported for the committee appointed to consider the advisability of having more frequent meetings as follows:

1st. That another scientific meeting be held in addition to the regular meeting held on the second Tuesday of the month; that this additional meeting be held on the fourth Tuesday of each month.

2nd. That the additional scientific meetings be devoted to general discussions or symposia on various subjects, to be determined and selected.

3rd. That arrangements be made for meetings to which prominent attorneys, judges, etc., be invited, and also other meetings to which representatives of the ministerial profession be invited.

4th. That a special committee of three be appointed to have charge of these special meetings and to conduct systematic efforts toward better organization in San Francisco. This special committee to work with the Executive Committee of the society.

5th. That provision should be made in some way for supplying the newspapers of the city with reliable statements in regard to public health matters and similar information which the public should receive, and which can only be given to it by the medical profession. This is hardly included in the resolutions creating the committee, but it seems to be in line with some of the work hereinbefore recommended.

Dr. Jones moved that this report be adopted. Motion carried.

Dr. Sherman requested that the recommendations of this report be read again. This was done and they were discussed seriatim.

Dr. Carpenter moved that the first recommendation, establishing meetings twice a month, be adopted. Motion carried.

It was moved and seconded that the second recommendation be adopted. Motion carried.

Moved and seconded that the third recommendation be adopted. Motion carried.

Moved and seconded that the fourth recommendation be adopted. Motion carried.

Moved and seconded that the fifth recommendation establishing a press committee be adopted. Motion carried.

Dr. Evans moved that a press committee of three be appointed in line with the suggestion of the last recommendation be adopted. Motion carried.

Dr. Jones moved that the secretary be instructed to purchase a scrap book and in that scrap book there be pasted any clippings from the daily papers referring to any of the members of this society. A space is to be left after each clipping in which the member involved can write his defense. This scrap book to be placed in the library for the inspection of the members. Motion carried.

Dr. Blumer requested that the Library Committee be allowed \$800 for current expenses in the next six months.

Dr. Jones moved that the Library Committee be allowed \$800 for the next six months to be used for payment of salaries, payment of rent, etc. Motion carried.

Dr. D. Tait resigned as delegate from the State Society, nominating Dr. Brunn in his place. Resignation duly accepted and Dr. Brunn was duly elected to fill the vacancy.

Meeting adjourned.

PAST PRESIDENTS.

As this is the semi-centennial of the State Society, it may be of interest to our members to recall the names of those who have, in the past, guided the society through its many storms and stresses and into the comparatively quiet waters of the present time. We therefore give a list of the past presidents of the society; those marked (*) are deceased.

Year.	Place of Meeting.	Presiding President.
1856	Sacramento	*B. F. Keene
1857	Sacramento	*H. Gibbons
1858	San Francisco	*A. B. Stout
1859	Sacramento	*R. B. Ellis
1870	San Francisco (Incor. Nov. 1)	*T. M. Logan
1871	San Francisco (Mar. 1)	*T. M. Logan
1871	Sacramento (Oct. 11)	*T. M. Logan
1872	Oakland (October)	*H. Gibbons
1873	Sacramento (April)	*G. A. Shurtleff
1874	San Francisco	*T. H. Pinkerton
1875	Sacramento	*J. M. Browne
1876	San Francisco	*A. B. Nixon
1877	San Francisco	*Wm. Fitch Cheney
1878	San Jose	*Washington Ayer
1879	San Francisco	*H. S. Orme
1880	San Francisco	*A. W. Saxe
1881	San Francisco	*F. W. Todd
1882	San Francisco	*G. G. Tyrrell
1883	San Francisco	*L. C. Lane
1884	San Francisco	*Iva E. Oatman
1885	San Francisco	*R. Bev. Cole
1886	San Francisco	*W. P. Gibbons
1887	San Francisco	*W. S. Thorne
1888	San Francisco	*R. H. Plummer
1889	San Francisco	*Jas. Simpson
1890	Los Angeles	Walter Lindley
1891	Sacramento	W. R. Cluness
1892	San Francisco	O. O. Burgess
1893	San Francisco	W. E. Taylor
1894	San Jose	C. G. Kenyon
1895	San Francisco	G. L. Simmons
1896	Los Angeles	Wm. LeMoyne Wills
1897	San Francisco	Henry Gibbons, Jr.
1898	Fresno	*Cephas L. Bard
1899	Del Monte	*Wm. Watt Kerr
1900	San Francisco	*Geo. Chismore
1901	Sacramento	*Thos. Ross
1902	San Francisco	Wm. J. G. Dawson
1903	Santa Barbara	F. B. Carpenter
1904	Paso Robles	H. Bert. Ellis
1905	Riverside	Frank L. Adams

COMMUNICATIONS.

Fraudulent Subscriptions.

To the Editor of the STATE JOURNAL: We notice in your issue of February, 1906, a paragraph concerning a fraudulent subscription solicitor who has been soliciting subscriptions to *Sunset Magazine* and other periodicals from doctors in the southern part of this state.

We first heard of this man's actions in January and succeeded in locating him in Los Angeles. We had him arrested and he was tried, found guilty and sentenced to five months' imprisonment, which sentence he is now serving.

We have been placing upon our complimentary lists all doctors and others who have been defrauded by this man, not because of any liability on our part, but because we feel we can better afford to place the doctors upon our lists than to have them prejudiced against *Sunset*. We are writing Doctor Gordon making this offer to him, and if you learn of any other doctors who have been defrauded, you will confer a favor upon us by sending us their names. Yours very truly,

JAS. HORSBURGH, JR.,

A Denial.

To the Editor of the STATE JOURNAL: In your March number you have reprinted an article published in the *Medical Record* of January 13, 1906, in which reference is made to criticisms advanced by friends of the College of Physicians and Surgeons of Los Angeles, against the State Board of Medical Examiners. The name of the College of Physicians and Surgeons of San Francisco has been brought into the discussion. I wish to assert that this College has had nothing whatever to do with the discussions and criticisms carried on between the College in Los Angeles and the State Board, and I regret exceedingly that our name should have been used at all in this connection. We have no quarrel with the Board of Medical Examiners. We know nothing whatever of the merits or demerits of the criticisms and discussions above referred to. We prefer to be left out of the matter entirely. I hope you will do us the favor and the justice to give this communication publicity in your April number.

Yours very truly,

D. A. HODGHEAD, Dean.

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[Another correction in the article quoted from the *Medical Record* is furnished by the following personal letter from the President of the Board of Examiners to the Dean of the College of P. and S., San Francisco.]

MY DEAR DOCTOR HODGHEAD: In reply to yours of yesterday, permit me to state:

1. Life is too short and too busy for one to reply to every attack or to correct every error that may reflect upon oneself.

2. I have never publicly or privately expressed any opinion derogatory to either the P. and S. of Los Angeles or of San Francisco. In the former college I happen to have half a dozen old and valued friends—in its faculty. In the latter, Morton is the only man I know, and Morton has treated me with more than ordinary courtesy.

3. If I have any grudge against either college, which I have not, I am not fool enough to make the assertion credited to me, as president.

4. As a member of the Board of Examiners I do not discriminate for or against any college, nor do I think any one ever seriously accused me of doing so.

5. I am not the member of the board referred to in the article you mention. The latter part of that article clearly shows that the examiner in pathology was intended by the writer. Unfortunately for the

state, that examiner is not now president of the board. The writer got mixed.

6. During two years of somewhat intimate association with the examiner in question, Dr. Dudley Tait, I have never heard him express the views attributed to him in said article—nor do I believe he ever did.

7. You are at liberty to use this statement as you please. I can only add that as an examiner my experience with applicants from your school has given me no occasion to discredit the institution in any manner.

8. I have never met you, but as a delegate to the Santa Barbara meeting I felt it to be my duty to vote against you, which I did. At the same time I greatly admired your pluck in making a fight you knew to have been lost from the start. You put your back to the wall and made a talk that won the admiration of all who were not too prejudiced to appreciate its bravery. I have since then hoped for an opportunity to meet you and I still look forward to the pleasure of a personal acquaintance with you.

Very sincerely yours,

JOHN C. KING.

Small Fees Dangerous.

In reply to the circular letter giving notice of the cut in fee for examinations for the Mutual Life of New York, one of its former examiners has sent the following letter:

Brandreth Symonds, M. D., Medical Director N. Y. Mutual Life Ins. Co.—

DEAR DOCTOR: Your communication of February 15, 1906, relative to medical examiners' fee, received.

I wish to assure you and your company that it is the most decided disappointment I have so far received concerning the Mutual. Not that the few dollars less which I, as one of your medical examiners, will receive from you will materially affect my financial standing, but for the following reason:

Some years ago, when first beginning business, I felt that I should always carry as much life insurance as I could conveniently; naturally the next thing was to select what I thought to be the best company; I staked my judgment on the Mutual. Do you know anything about how a man feels when he finds that his judgment has stood him in error?

I have from time to time taken out a small policy with your company, until now the total amount is \$16,000.00; to-day, sir, upon reading your letter I felt qualmish, experienced the first doubt as to the wisdom of my investment. Such questions as these came to mind:

Can any life insurance company hope to attain to a high measure of success without the ready co-operation of the *very best* medical talent in the land? Can this be secured by a remuneration of a paltry three dollars for work that requires from one-half to one hour? Are the *very best* medical men so trivially paid by any other class of patrons? If the company cannot secure the most desirable class of medical men to work for it for three dollars, why not make the fee one dollar (and save more)? the woods are full of "doctors" who will work for one dollar. And if you cannot afford the best, is it worth while having a medical examination at all? The company would probably exist for an uncertain length of time if it accepted risks without examination. Do you get the full value of a poorly paid laborer in any line of work?

Did the Mutual Life Insurance Company arrive at its present standing as one of the most stupendous financial institutions in the world through a parsimonious line of dealing with its medical examiners in the past?

Now please be assured that merely for the loss of two dollars on an occasional examination I should not have wasted time on this communication, but

from the standpoint of a man who has for several years past been making payments on what he thought to be a good thing, I am thoroughly aroused. I am anxious. A ship that continually puts to sea without proper examination of the hull is liable to sink; a life insurance company that carries a line of poorly paid medical examiners—well, just contemplate the possibilities!

You refer in your communication to this being "A purely mutual organization"; now as one of the company, I want to be heard; please be good enough to read and digest this yourself, and then pass it along.

And as a final suggestion I would say, that if you wish to promote the prosperity and solid standing of this company, face about and do all in your power to secure the adoption of a uniform fee for medical examiners of ten dollars. Tell the officers to practice retrenchment among the sinners; and not to take away the loaf from the poorest paid, and at the same time the most important branch of your organization. I am, my dear sir,

Very sincerely yours,

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Enucleation Questioned.

To the Editor of the STATE JOURNAL: Kindly grant me space for a few lines of comment on one topic in Dr. Frank Allport's article in your February issue regarding treatment of ocular injuries, for I believe that his advocacy of enucleation for panophthalmitis is decidedly apt to do harm with less experienced operators. Every one is, of course, agreed with the doctor in his absolute statement that meningitis from panophthalmitis is extremely rare. I must confess, therefore, to be at a loss to understand him when he says almost immediately afterwards, "Cases of purulent panophthalmitis rarely produce meningitis, as before this calamity occurs the pain and suffering become so severe as to induce patients themselves to be quite willing to be relieved by an enucleation." Ever since von Graefe in 1863 reported the first two deaths from meningitis after enucleation for panophthalmitis, ophthalmic surgeons have held that the operation under such circumstances is a most dangerous undertaking, risking, as we are putting it nowadays, the entrance of micrococci (pyococci and pneumococcus) into the (rigidly) open lymph and blood channels. Otto Becker's* critical statistics of 43 deaths from meningitis after enucleation have established the great danger of the operation in panophthalmitis.

If we could always determine clinically whether in a case of panophthalmitis we are still dealing purely with a uveitis suppurativa, not having involved the sclera and especially not yet having reached Tenon's capsule and the general orbital tissues (causing proptosis), we could say that enucleation for simple uveitis suppurativa is justifiable, whilst on the other hand most dangerous in the extended forms of panophthalmitis. Since it is impossible, however, to thus rigidly draw the line between intra and extra-ocular panophthalmitis, we must declare against enucleation as a general method.

Exenteratio bulbi if done *lege artis* i. e., antiseptically and without leaving anything behind of the uveal tract, but anticipates the phthisical stump as the result of spontaneous healing of panophthalmitis, hence must offer the same safeguard against meningitis, and against sympathetic ophthalmia as well, which latter occurs but extremely rarely after panophthalmitis either.

Respectfully,

C. S. G. NAGEL.

From a therapeutic viewpoint it is a great error to class rheumatoid arthritis as rheumatism, since in its treatment the use of tonics, a liberal diet, electricity, and massage are indicated rather than the free administration of the salicylates, which at best only relieve the pain.—*International Journal of Surgery*.

*Die Universitäts-Augenklinik in Heidelberg. 1888.

MEDICAL SOCIETIES.

CALIFORNIA ACADEMY OF MEDICINE.

Meeting held January 20, 1906, the president, Dr. P. K. Brown, being in the chair.

Atheroma of the Aorta. Dr. Wm. Ophüls demonstrated specimens of atheromatous aorta which had been injected at blood pressure with paraffine. Contrary to Thoma's contention, these show no bulging of the muscle beneath the atheromatous plaques. Since they were taken from an early stage in the disease, they show very clearly that the thickening of the intima is not caused by any primary weakening of the muscularis. The newer histological methods favor the view that arterio-sclerosis is an inflammatory condition.

Genu Recurvatum. Dr. H. M. Sherman showed a boy, 15 years old, who suffered from an extreme genu recurvatum. As an infant he had had a spinal kyphosis that had been cured by a plaster jacket. A little later he developed a tuberculosis of the left knee joint. At 8 years an erosion of the joint was done and two later operations were performed on the knee, in one of which the external popliteal nerve was cut. The deformity of the knee is extreme and is increasing and the boy suffers pain after walking a few blocks. Dr. Sherman stated that in his own experience an erosion of the knee joint is practically always followed by a tendency to flexion, which latter takes place even though the joint be in splints. This flexion proceeds to about 35° and then stops. It is much less likely to take place if the continuity of the extensor tissues over the front of the joint be preserved. The patient here exhibited reverses the ordinary rule and shows extension instead of flexion.

Dr. Rixford stated that the radiograph shows that the line of the lower end of the femur is obliquely placed, the posterior edge of the femur projecting downward farther than the anterior. We cannot tell whether this resulted from an extensive operative excavation of the anterior part of the femur, from an absorption of the anterior part of the bone, or from an excessive growth of the posterior portion. The after treatment of the case may have been such that the knee tended to sag as it would if the leg had been supported by the heel. Similar deformities occur not infrequently when fractures of the leg are treated by Plaster of Paris splints.

Hydrocyanic Acid Poisoning. Dr. T. C. McCleave reported a series of cases of hydrocyanic acid poisoning that had resulted from the attempt to exterminate the roaches in a lodging house. The poisonous fumes diffused to distant parts of the house, especially through an open clothes chute. The patient most severely affected stated that after noticing the odor of the gas, she felt nauseated and dizzy and then vomited profusely. After a brief period of fullness and whirling in the head, she became unconscious. When discovered shortly after, she was extremely cyanotic, the mucous membranes were injected, and the muscles rigid. Urine was voided involuntarily. She remained unconscious for about eight hours. She was given artificial respiration, oxygen, and the usual cardiac and respiratory stimulants. Epinephrin, in the form of adrenalin chlorid solution, 45 minims, seemed to determine the recovery more than did anything else. Headache, nausea, and vomiting persisted for some days. The cyanosis also lasted for some days and seemed to be dependent on changes in the blood itself. In addition to this patient, all who had assisted in removing her from the room were more or less affected, being prostrated with headache, vertigo, nausea, and vomiting. The blood examination of one of these showed 4,000,000 red cells; 9,000 leucocytes; and a normal differential count. The urine was scant and smoky but showed no albumin.

Dr. Rixford spoke of the value of epinephrin in surgical shock. He has seen the blood pressure rise markedly after injections of this substance, and in one case in which strychnine and salt solution had been previously administered, he felt confident that the epinephrin solution had saved the patient's life.

Dr. Ophüls stated that the action of epinephrin solutions in large doses seems to be very uncertain when injected into rabbits. On one day a rabbit will tolerate a certain dose very well; whereas on the next day it will succumb in a few minutes to the same dose from the same bottle.

Thyroid Operations. Dr. W. I. Terry reported a series of nine operations on the thyroid gland with no deaths. Eight of these patients had more or less severe symptoms of exophthalmic goitre and all were improved as a result of the operation. In several, the X-ray and the serum treatments had been previously tried without success. In all the right lobe was much larger than the left. The operation was essentially that elaborated by Kocher. A local 1% cocaine or eucaine anesthesia was employed and the speaker felt confident that the pain during the latter parts of the operation were not to be measured with the dangers of a general anesthetic. In one patient while tying the inferior thyroid artery, the voice suddenly became squeaky and it only needed a readjustment of the ligature to free the nerve which was not itself seen. The collar incision was preferred both because it gives a better exposure of the gland and because it leaves a better cosmetic result. The individual vessels were isolated and tied. As a rule the stump of the gland was cauterized with carbolic acid and a small drain was left in for 24 hours.

Paroxysmal Tachycardia Associated with Exophthalmic Goitre. Dr. P. K. Brown reported in detail one of the cases that had been operated upon by Dr. Terry. A woman, 41 years old, gave a history of paroxysmal tachycardia since she was 12 years old. One of her children also has these attacks. She was observed in several paroxysms of tachycardia, during which her pulse rate reached 280 per minute. Gradually a small goitre developed associated with tremor, general nervousness, pigmentation of the skin, and marked general weakness. Over a period of two years, she was treated with various medical remedies, including two kinds of dried serum from thyroidectomized animals and the X-ray, but without any other effect than could be accounted for by the rest in bed. After a part of the gland was removed she improved immediately and considerably.

Dr. Cheney stated that he had treated six cases of exophthalmic goitre with thyroidectomy and that in four the results have been very satisfactory. The nervousness, tachycardia, exophthalmos, and tremor have all disappeared. The goitres however have remained. In one of these cases the remedy has now been suspended for three months and no symptoms have recurred. Many cases of exophthalmic goitre seem to run a self-limited course and if the symptoms can be relieved the disease will terminate of itself. Others must come to the surgeon but the operation should be a last resort and should not be performed until medical treatment has been given a fair trial.

Dr. S. Stillman stated that he has now under his charge for other conditions two patients who had previously suffered from exophthalmic goitre with enlargement of the thyroid, rapid pulse, and tremor. They had both recovered spontaneously. He is not in favor of early operations on comparatively mild cases.

Dr. E. Rixford advocated the use of thyroidectomy as a preliminary to operation. By its use the danger of the operation may be materially reduced; especially when the tachycardia improves and the heart recovers its tone.

Dr. Dudley Tait stated that he had recently visited Jaboulay's clinic in Lyon and had seen some of the results that follow sympathectomy. The exophthalmos and enlargement of the thyroid are nearly always improved. Patients with marked nervous symptoms and those with pronounced tachycardia are not considered favorable subjects for this operation. The operation is comparatively free from danger. The difficulty with local anesthesia in this country is that the people do not realize the dangers of general anesthesia and are not tolerant to pain. For this reason many operators find it necessary to use ether in goitre operations.

A. W. HEWLETT.

SAN FRANCISCO SOCIETY OF EYE, EAR, NOSE AND THROAT SURGEONS.

Regular meeting January 18, 1906, Dr. George Merritt in the chair.

"The Adjusting of Eye-Glasses and Spectacles," Dr. George Brady.

Dr. Brady called attention to the necessity of the oculist understanding the underlying principles of this subject. Usually the optician has this part of the prescribing of glasses entirely in his hands. All of us get cases where it is advisable to give the optician exact instructions in regard to the necessary changes and, for this reason, a working knowledge of the subject is indispensable. The doctor explained the technical procedure of fitting, having numerous frames to make the work practical.

Dr. Pischel said that he considered this the work of the optician and sends his patient back as often as he finds that the glasses are not properly adjusted. In this way the optician is made to realize the importance of his work, and thus becomes educated to the fact that a little care in the beginning will save him extra work.

Dr. Eaton mentioned that often there exists asymmetry of the face, with the result that one eye is nearer to the nose than the other. This point is frequently overlooked by the optician.

Dr. Brady, in closing, said that he has noticed this asymmetry of the face repeatedly; in fact, it is the rule, and not one face out of twenty is really symmetrical.

Dr. Eaton described a case of injury to the eye. The patient came, complaining of pain in an eye which had been injured with a piece of glass six years before. The glass had cut the cornea and sclera over the ciliary body, and had evidently penetrated into that region. The bulbous was tender to the touch and atrophied. Enucleation was recommended. A piece of glass was found in the orbital fat, and it was necessary to go behind Tenon's Capsule. After 48 hours the stump was movable in the usual way but, instead of being cup-shaped, was rather convex or pushed out. The next morning he was informed that the patient had convulsions, epileptoid in character, during the night, and extreme pain in the stump. This latter was now collapsed and a thin serum-like substance exuded. He had no further symptoms, the orbit healing promptly.

Dr. Nagel wished to know whether the man had ever had similar fits.

Dr. Franklin said that a temporary pressure extending to the brain cavity could explain the condition.

Dr. Eaton, in closing, explained that as he went behind the capsule slight sepsis might have been present with increase of the arachnoid fluid, thus causing the convulsions by pressure. The symptoms subsided as soon as the stump drained.

Dr. K. Pischel showed the following case: Patient, a miner, was injured about one year ago by the explosion of a blast in a quartz mine. He was treated in Denver; the inflammation passed off and the patient returned to his work. Examination showed scar in the center of the cornea of the right eye, iris

adherent to same. Hanging to the iris is a small piece of quartz, $\frac{1}{2}$ mm. in diameter. Pupil covered partially with a secondary cataract, substance of lens absorbed, with clear space remaining in the upper portion. In the cataract fine sand. Disc shows some whitish scars, and below a tear in the choroid. X-Ray picture was taken in Denver and three opacities were seen. The question is: "Are we to attempt operative removal of the foreign bodies and failing enucleate the eye or leave the eye alone?"

Dr. Eaton would leave the eye alone if the man was sufficiently intelligent to return upon the first sign of irritation.

Dr. Nagel agreed with Dr. Eaton, and would leave the eye alone as long as there was no secondary glaucoma, shrinkage or other signs of active irritation.

Dr. Franklin thought that as the foreign bodies were attached to the iris it would not be difficult to remove them, and all that was necessary was removal of that portion of the iris containing the foreign bodies. The man being a miner and, through his occupation, living in remote places we should not subject him to the possibility of sympathetic ophthalmia without the proximity of a competent oculist.

Dr. Pischel, in closing, said that he thought the eye could stand these foreign bodies very easily and he would not suggest removing same. The man sees the movement of the hand readily and can distinguish fingers outwards and downwards.

Meeting of February 3, 1906.

The president, Dr. George Merritt, in the chair.

Dr. Fredrick reported "An Unusual Case of Mydriasis," saying that the patient, a man, presented himself with complete dilatation of the right pupil which had come on suddenly over night. The left was partially dilated. He was at a loss to know the cause; he had put nothing into the eyes, and nobody in the house had eye trouble. He had had a similar attack once before. Patient had asthma and was using a patent medicine for same. Such remedies often contain soda and belladonna. The circular read that when taking this medicine one must abstain from all alcoholics and patient remembered that he had taken a glass of wine after the remedy. The mydriasis was overcome with eserine. "We should all be on the lookout for similar cases of so-called 'Idiopathic Dilatation,' which in fact are due to some remedy which passes by unsuspected."

Dr. Martin reported two cases in which the mydriasis was caused by the use of suppositories for hemorrhoids.

Dr. Merritt remembered having seen bilateral dilatation after the use of belladonna-plasters applied to the back.

Drs. Brady and Pischel reported similar cases of bilateral dilatation due to the internal use of belladonna in some form or other.

Dr. Fredrick reported, "Darier's Results with Radium," saying in closing: "There are, at present, a large number of men experimenting in this direction but as radium is so expensive it is practically impossible for the individual to have some of it. I suggest that the society buy a small amount out of its funds and in this way open the field for further investigation."

Dr. Pischel showed the new chisels of Miles, of New York. They are particularly useful in sinus work, entering easily forward and cutting out a piece when pulled backwards. They are extremely useful within the sphenoidal sinus as the chisel enters easily and an assistant, by hammering, gets out a piece of the anterior wall. In operating on the antrum Dr. Pischel shoves back the mucous membrane, makes a small opening and then with the chisels, just described, enlarges same saving the membrane as much as practical. He has seen a case where the face was edematous the next day after the use of these chisels.

Dr. Welty considered these chisels too sharp for the sphenoidal cavity and not suitable, as the wall is often as thin as paper and one is working close to the brain in a cavity already infected. He does not consider the opening of the antrum through the nose as sufficient but does the radical operation.

Dr. Philip thought that Miles' instruments were well adapted for this class of work and particularly in removing the anterior wall of the sphenoidal cavity. As these instruments cut principally backward and do not go upward he did not see how any of the important structures could be endangered.

Dr. Martin said that all instruments are dangerous in unskilled hands but that these instruments, though perfectly safe, would not help us much so far as the sphenoidal sinus was concerned. He thought the edge too round to cut into the hard bone at the base of the sphenoid.

Dr. Pischel, in closing the discussion, said that the question of danger in regard to these instruments had been answered by Dr. Philip. One works only downward and outward with them. He does not consider them as sufficiently strong for the thick bone at the lower part of the sinus. Dr. Miles does not pull them out but has his assistant use the hammer backwards, in this way avoiding tearing the walls.

"A Persistent Case of Episcleritis," Dr. Geo. H. Powers. The patient, a woman about 30 years of age, came with the right eye showing marked episcleritis. She was well otherwise and examination showed no constitutional disease. Dr. Powers treated the patient on the assumption of rheumatism, giving large daily doses of the salicylates. After lasting seven months the eye cleared and patient has not had a return of the trouble. The case was peculiar inasmuch as there was no evidence of rheumatism, although treatment established that it was the cause of the condition.

Dr. Martin said that he had used dionin with good results, but cases of episcleritis are exceptionally obstinate to treat and some of them last seven or eight months in spite of the most approved treatment.

Dr. Barkan did not consider this an excessive length of time for such a malady and cited a case of his which resisted all local treatment and was cured only when sent to one of the Hot Springs with the resultant constitutional regime.

Dr. Nagel emphasized the necessity of keeping the possible luetic origin of this trouble before us. He had a case which resisted the usual salts and although lues was not marked the inunctions of mercury were immediately beneficial.

Dr. Eaton, mentioned that he had found two efficient remedies for this condition, one being colchicin, recommended by Darier, the other citarin. This latter remedy he uses in the most persistent cases and has seen it clear up an obstinate one in 48 hours.

Dr. Powers, closing the discussion, mentioned that he had forgotten to say that he had tried dionin without result and the case was presented as it differed, to his mind, from the ordinary episcleritis, which, at best, is a sluggish disease.

W. SCOTT FRANKLIN, Secretary.

THE PROPRIETARY MEDICINE FROM THE PHARMACIST'S STANDPOINT.

"In the eyes of the professional pharmacist, the physician prescribing any of these preparations is either an ignoramus or a charlatan, or both, mostly both. The pharmacist is compelled by law to be thoroughly familiar with the drugs he dispenses, and to examine them for purity, etc. The 'caveat emptor' of ordinary commerce is changed into 'caveat vendor' in the case of pharmacy. With chemicals, even of those protected by patent, which are really scientific discoveries, he can easily assume responsibility. Chemical tests are at his command. But

what can he do with preparations which never had a chemical test, and never could have a chemical test, because they are mechanical mixtures, and because the manufacturers can and do change their composition at will. The M.D. who prescribes these preparations is on a par with the customer who buys Lydia Pinkham's, or Father John's, with this difference: that the layman who takes the statements of the manufacturer for truth pays for it himself, while the doctor makes the patient pay for it, and often gets a little rake-off from the manufacturer in the shape of discount.

Let us now view the effect which the prescribing of such remedies has on the three classes most affected.

First comes the physician. After the detail man or the manufacturer's ad. has insulted the M.D.'s intelligence by telling him what to prescribe, the manufacturer proceeds to separate the doctor from his patients in a most ingenious manner. He tells the M.D. that to insure the genuineness of the preparation he must write for an original bottle. Right here he undermines his friend, the M.D., for before very long the article has been so well introduced by the aid of the guileless M.D. that the people buy it over the counter without paying the M.D. his fee for recommending it. This is the financial phase for the M.D.

There is also another phase. When the M.D. has become accustomed to let the detail man think for him, he has given up medicine thinking altogether. His first impulse after diagnosing a case is to call for some proprietary remedy, irrespective of what its actual constituents may be, without regard to idiosyncrasies in the patient and without the possibility of knowing what secondary effects that particular dope may produce. Often he is puzzled by what he supposes to be newly developed symptoms, which are nothing less than after effects from some of the constituents of the (to him) unknown remedy. The effect on the patient is a matter not to be lightly passed over. We pharmacists often have occasion to judge it.

I will relate an incident which happened not long ago in my store. A lady brought in a prescription asking for a proprietary tablet whose chemical test consists of the monogram on top. After receiving the medicine she opened the box, and on discovering that the tablets were old friends of hers, which she had been buying in 25-cent boxes over the counter, she said some very uncomplimentary things about the M.D. and wound up by declaring that hereafter she would consult a doctor who wrote 'real medicine.' The evil of self-medication is largely due and directly attributed to the prescribing of proprietary preparations by the M.D.

To compel the druggist to dispense preparations of this ilk, is to rob him financially and to insult him professionally. He is compelled to stock up on 40 to 50 acetanilid preparations, the numberless bromide mixtures, the legion of dope cure-alls, and simply because the physician is too indolent or too ignorant to compose his own prescriptions.

That there are a number of valuable preparations of proprietary origin, nobody will deny. That the M.D. has a right to use them in his daily practice is equally true, but it is up to the physician to differentiate between an ethical proprietary and a fake with a high-sounding name, and when in doubt there is always at the command of the practicing physician that great and, alas, often neglected, book, the United States Pharmacopeia.—P. J. Diner in *Am. Druggist*.

After removal of the appendix symptoms of appendicitis sometimes persist, leading the patient to believe that the organ had not been extirpated. These are generally due to a colitis, which must be treated by high irrigations, diet, etc.—*International Journal of Surgery*.

PUBLICATIONS.

The Physical Examination of Infants and Young Children.—By THERON WENDELL KILMER, M.D., Adjunct Attending Pediatricist to the Sydenham Hospital; Instructor in Pediatrics in the New York Polyclinic Medical School and Hospital, New York; Attending Physician to the Summer Home of St. Giles, Garden City, New York. Illustrated with 59 halftone engravings. 12mo., 86 pages. Bound in extra cloth. Price, 75 cents, net. F. A. Davis Company, publishers, 1914-16 Cherry street, Philadelphia, Pa.

The recognition of disease in infants and young children depends almost exclusively upon objective study; therefore, the physical examination assumes even greater importance than in the adult. Text-books do not always emphasize this sufficiently.

Dr. Kilmer, within the compass of a small manual of 86 pages, has very clearly brought out the salient features of physical examination in this class of patients. It is to be regretted that the plan of the book did not permit of more extended discussion of the topographical anatomy, menstruation, and other allied topics. Considered as a whole, the book will prove extremely useful to students taking up the study of pediatrics.

A. J. L.

Lectures on Autointoxication in Disease, or Self Poisoning of the Individual.—By CH. BOUCHARD, Professor of Pathology and Therapeutics; Member of the Academy of Medicine, and Physician to the Hospitals, Paris. Translated, with a Preface and New Chapter added, by THOMAS OLIVER, M. A., M. D., M. R. C. P. Second revised edition. 342 pages, extra cloth. Price, \$2.00 net. Philadelphia. F. A. Davis Company, 1906.

The second edition of this well-known book comes from the press without further original work by Bouchard. However, Oliver, the translator, has amplified the text to some extent, and has added an appendix in which the inter-relations of organs, and their roles in toxic conditions, are discussed.

Bouchard's book is the pioneer in autointoxication, and has done great good in stimulating thought in that direction. If any criticism be made it is that the work is not carried far enough. There is no field which offers more opportunity for biochemical research than autointoxication. With improved methods for isolating organic poisons, the etiology of many conditions, such as arteriosclerosis and some forms of cirrhosis of the liver and kidney, may be cleared up. Every student of medicine should have read this work, the clinician as well as the laboratory worker. The clinician particularly would be well repaid by the chapters dealing with the gastro-intestinal tract.

J. B. F.

Neurotic Disorders of Childhood: Including a Study of Auto-Intestinal Intoxications, Chronic Anemia, Fever, Eclampsia, Epilepsy, Migraine, Chorea, Hysteria, Asthma, etc.—By B. K. RACHFORD, M.D., Professor of Diseases of Children, Medical College of Ohio, University of Cincinnati; Pediatricist to the Cincinnati, Good Samaritan and Jewish Hospitals; Member of American Pediatric Society, Association of American Physicians, etc. E. B. Treat & Co., New York.

Anyone who has had experience with infants and children must have been impressed with the physiological peculiarities of their immature nervous systems, and the bearing which these peculiarities have upon the production and individuality of the neuroses of childhood. This point was well illustrated by Dr. Rachford in a series of extremely interesting papers published several years ago. The importance of the subject is at once apparent; this induced the author to utilize them in revised form as the nucleus of the present volume.

The first part of the book is mainly devoted to a consideration of the role of various auto and bacterial

intoxications in their etiology. Although we do not believe that all the statements should be accepted in toto, the point of view is very suggestive. The remainder of the book deals more particularly with the individual neuroses, such as eclampsia, tetany, enuresis, recurrent vomiting, chorea, habit spasm, etc.

Dr. Rachford's book is both stimulating and enjoyable. It is to be especially recommended to the general practitioner.

A. J. L.

Nasal Sinus Surgery With Operations on Nose and Throat.—By BEAMAN DOUGLASS, M. D. F. A. Davis Co., Pub., Pa.

The author says, "This little work on Nasal Sinus Surgery has been written because of demands made for such a book by physicians who have worked under my directions."

This book is a welcome addition to the literature of sinus operations for there has been no complete work, in English, on this subject. The plates are an attractive feature of the work and assist the reader in comprehending the text; however, some of the half tones are lacking in clearness and might well have given place to a few schematic drawings. Favorite preparations of an author never have the same meaning to the public as to him who has labored over them and verified the landmarks with a probe. So much space has been given to the anatomical and historical notes that the descriptions of operations bear evidence of a desire to abbreviate at the expense of clearness. The description of the operation for opening the ethmoid cells is one of the best which the author gives us, the description being clearer than is to be found in any other text-book.

Enucleation of the tonsil is mentioned but this popular and valuable procedure is not described. The author still adheres to the tonsillotome and tonsil punch.

Five pages are devoted to a description of the operation for removal of adenoids of which, two pages are taken up by a description of its dangers. Whilst it is not well to minimize these dangers, they must be of rare occurrence as few operators have encountered them, and it would put a different complexion upon the indications for operation, if it were likely to be found necessary to "strip the larynx," "invert the patient," or "do tracheotomy." The author advises that the operator have always a tracheotomy tube at hand when operating.

On the whole the book is the best resume of the subject but is more useful in giving a general sketch of the subject than as a working manual for operators.

A. B. McK.

A Manual and Atlas of Orthopedic Surgery, General and Special, Including the History, Etiology, Pathology, Diagnosis, Prognosis, Prophylaxis and Treatment of Deformities.—By JAMES K. YOUNG, M. D. Illustrated with over seven hundred photographs and line drawings, mostly from original sources. Octavo. Cloth, \$10.00; half morocco, \$12.00 net. P. Blakiston Son & Co., Philadelphia, 1905.

This volume of rather encyclopedic extent and possessing some considerable interest as a dictionary, purports to be intended for the use of students and practitioners of medicine, but it can hardly be discussed as a serious exposition of modern scientific medicine. Taking the subject of hip disease, for instance, one is at once struck with the rather peculiar ideas of the author, which are not in accord with modern opinion. It is true that the author is a man of wide experience, but when he locates the primary focus in hip disease differently from the best authorities, when he states that thickening and hardening of the trochanter can be accepted as evidence of pus in the joint; that irritation of the tubercle bacillus generally causes lengthening of the limb; when one

sees the value he places on the X-ray for locating foci in the early stages, one wonders why he offers no evidence. These differences may, however, be explained perhaps by individual judgment, but when an author states in a modern text-book, without winking, that the pallor accompanying cold abscess is due to the increased number of white corpuscles in the blood—that phymosis is a factor of importance in the etiology of hip disease—that hip disease is rather favorably modified by pulmonary infection—that syphilis of joints is often transmitted from grandparents, the parents being free, one wonders with what old lady he collaborated and doubts the value of the book as a Manual of Orthopedic Surgery. As an atlas, however, it is good, numerous plates and good plates illustrating every section. There is rather a good article on scoliosis, the writer describing with much detail splendid systems of gymnastics, but here he fails to note the work of Schultheis and Wullstein, and the apparatus of Wullstein, which is probably the most efficient appliance towards the correction of scoliosis. The article on tendon transplantation is old and not given the importance it deserves, and the work of Lange totally ignored, and no mention made of the use of silk tendons. It is a pity that the vast material in the hands of the author did not receive some revision before this edition was offered. The book looks well—the print is large and new, and although the proof-reading is careless, the work would be an ornament to any shelf.

S. J. H.

Genito-Urinary and Venereal Diseases.—By J. WILLIAM WHITE, M. D., John Rhea Barton Professor of Surgery, University of Pennsylvania, and EDWARD MARTIN, M. D., Professor of Clinical Surgery, University of Pennsylvania. Illustrated with 300 engravings and 14 colored plates, 1092 pages. Sixth edition. Published by J. B. Lippincott Co., Philadelphia and London.

The review of a work of this size and extent, containing as it does such a complete and exhaustive study of this branch of surgery and covering over 1000 pages of concise, judicious and logical statements relating to the diseases of the genito-urinary tract and syphilis, must, owing to the space allotted for such purpose, be incomplete and superficial. In the preface the authors give us an idea of what we are to expect. We are to look for "such procedures and facts as have been proven worthy of general acceptance," and with this for their text one can see on every page of the book the authors' decision to "hold fast to that which is true."

The trend of modern surgery is toward conservatism, and if this publication had been written by men more theoretical than practical, a critical mind might believe that the so-called recent advances made along diagnostic and operative lines had not been sufficiently emphasized, for instance: the operative cystoscope is only mentioned in describing the varieties of cystoscopes, nothing being said about its uses.

Less than two pages is devoted to urethral catheterization and while the purposes and dangers of the operation are mentioned it would seem that more might have been written on this important line of work, for it is self-evident that to the proper diagnosis of kidney lesions a separate examination of each organ is essential.

Of cryoscopy very little is said. The instrument is not even described, and the authors evidently do not consider it ever being a popular method of diagnosis, stating that "the intricate technique, even in skilled hands, is subject to many sources of error."

The advice given regarding the use of the cystoscope is in keeping with the conservative idea which, as stated before, prevails in every chapter and which corresponds with the opinion of many other experienced urologists, viz: "It should not be used till other means, except exploratory incision, have been

employed and the evidence obtained from them has been carefully weighed.

This is good teaching and makes the book particularly useful for the general practitioner, for if the use of the cystoscope had been inordinately praised, to the detriment of other careful methods, many inexperienced men would procure them, and damaged urethras and bladders would be even more plentiful than they are at present.

In the treatment of acute gonorrhea the same characteristic adherence to well-tried methods is particularly noticeable. In advising the selection of an injection they give us those formulæ which they state are "least irritating and most successful."

The irrigation method of treatment is carefully considered and the indications and contra-indications are well presented.

In studying the pathology of chronic gonorrhea the authors have followed closely the researches of Finger, and upon them have based their prognosis and treatment. This is, of course, the only practical, sensible method of dealing with this tiresome affection.

In comparing the chapter on syphilis in this edition with that of the third edition, published in 1897, one can see very little if any change in the text. It is evident that this publication was in the press before Schaudinn and Hoffman published their article on the spirocheta pallida.

A short section is devoted to the diseases of the ureter, wounds with methods of suture, stricture and calculus being dealt with quite fully. Considerable space is now devoted to the surgical diseases of the kidney, with liberal treatment upon the subject of their pathology. The description of operative methods is more minute than in other portions of the book. The so-called "renal epistaxis," often a puzzling condition, is not mentioned. Perhaps, too, the Edebohls' decapsulation for nephritis were better discussed in these chapters than elsewhere. Full justice is done the recent advances of kidney work, for example, Brûdel's incision in nephrotomy.

The chapters following deal with the testicle. The anomalies are rather fully dealt with. In that portion devoted to acute and chronic inflammations it would seem that insufficient space is devoted to the hygienic treatment of genital tuberculosis. Doubtless many patients who now come even for early operation could, in a large majority of instances, probably be permanently relieved without operation by being placed under proper sanitarium supervision. Tumors of the testicle receive cursory mention, followed by reference to scrotal diseases, hydrocele, etc. The remarks upon diseased conditions of the cord are needlessly drawn out and much repetition could be saved by more judicious arrangement.

In the chapter devoted to the prostate the inflammatory affections are duly dealt with. That portion dealing with enlargement of the organ has been completely rewritten and a splendid account of the pathology, symptomatology and treatment of this common distressing affection is very fully given. The operative technique is well and rather carefully described, embodying as it does the more recent procedures of various recognized surgeons. The author dismisses the controversy over choice of route in a few words. "The experience and aptitude of the operator, with the method to which he is accustomed, is of far greater importance in determining the choice of procedure than the character of the prostatic enlargement." In a mastery and conservative way White defends his operation of castration. Brief reference, perhaps too brief, is made to carcinoma of the prostate.

Regarding the use of the new form of index to which our attention is called by the publishers, one's opinion is naturally biased by the force of habit, and in consequence may be wrong. It is certainly a good synopsis of the book, and if one has plenty of time they could no doubt find the subject upon which they

desired information mentioned somewhere in the index. Under ordinary circumstances, however, a purchaser of a book does not desire to have his work increased, but rather diminished, by any changes made or innovations in the arrangement of an index.

One cannot but admire the book as being from a practical standpoint the best of its kind, particularly in this noted in the detailed definite manner in which the authors describe the symptoms of the various disorders and the clearness with which the differential diagnosis is outlined.

G. H. R.

REGISTER CHANGES.

Those members who desire to keep their Registers corrected up to date should check this list carefully. In the following will be found all the official changes (in California) received from the 15th to the 15th.

Allan, J. T. M., from add. unknown to 217 S. Broadway, Los Angeles.

Colburn, J. R., from Trust Bldg. to 515 Huntington Bldg., Los Angeles. Congdon, Maria Amsden, from 26 E. Colorado st. to 36½ Raymond ave., Pasadena. Hrs. 10-12 and 2-4. Curtis, R. G., from add. unknown to Hollister.

Davidson, Anstruther, from 501 Laughlin Bldg. to 546 Wilcox Bldg., Los Angeles. Dell, Lillian A., from 1084 Twelfth st., Oakland, to Agnew State Hospital, Agnew. Dillingham, F. S., from 540 Douglas Blk., to 422 Merchants' Trust Bldg., Los Angeles. Dodge, Clarence W., from 1169 Broadway to 1115 Broadway, Oakland. Hrs. 2-4 and 7-8. Dransfeld, C. S., from Lakeport, Lake Co., to 4160 Twentieth st., San Francisco.

Eddy, George S., from 2816 Central ave. to 408 Frost Bldg., Second st. and Broadway, Los Angeles. Hrs. 11-12 and 2-4.

Foster, Charles W., from San Pedro, Los Angeles Co., to Bolivia, S. A. Foster, Ernest C., from College City, Colusa Co., to Winters, Yolo Co.

Gedney, Frederick M., from German Hospital to 1610 Van Ness ave., San Francisco. Greenwood, Edna M., from add. unknown to 140 N. Third st., San Jose, Cal. Gresham, Arthur E., from Sierra Madre to 218 Pine ave., Long Beach, Los Angeles Co.

Hinkle, B. M., from Van Nyddock Apts., San Francisco, to New York. Hirschfelder, Arthur D., from 1392 Geary st., San Francisco, to Baltimore. Hopper, W. C., from 21 Powell st. to St. Paul Bldg., 293 Geary st., San Francisco. Hunkin, Samuel J., from 1616 California st., to 2135 Sutter st., San Francisco. Hutchinson, George L., from Huntington Bldg., to Pacific Electric Bldg., Los Angeles.

Jacobs, Louis Clive, from 2101 Pacific ave., to 1253 Polk st., San Francisco. Hrs. 1-4 and 7-8.

Kellogg, W. H., from 267 Devisadero st. to 297 Devisadero st., San Francisco. Hrs. 1-3.

Leonard, Ethel L., from Douglas Blk. to Fay Bldg., Los Angeles. By appointment. Libby, Arthur A., from 786 Orange Grove, Pasadena, to Bradbury Bldg., Los Angeles. Hrs. 10-12:30 and 2-4. Longabaugh, R. I., from add. unknown to Red Bluff, Tehama Co.

MacGowan, Granville, from 540 Douglas Bldg. to 422 Merchants' Trust Bldg., Los Angeles. Mayne, Wm. H., from Huntington Bldg., to 223 Pacific Electric Bldg., Los Angeles. Hrs. 11-1 and 3-5. Meyer, Albert G., from 2808 Folsom st. to 2651 Folsom st., San Francisco. Hrs. 1-3 and 7-8. Murrieta, Alfred J., from 765 College st., Los Angeles, to Jerome, Arizona.

Newton, John C., from 135 Geary st. to 293 Geary st., San Francisco.

Petch, L. G., from Eureka to Blue Lake, Humboldt Co. Petch, Thomas R., from Eureka to Blue Lake, Humboldt Co. Hrs. 10-12 and 1-3. Petter, Reginald S., from 1201 Central ave. to 853 Central ave., Los Angeles. Porter, C. L., from add. unknown to Long Beach, Los Angeles Co. Putnam, Harrison A., from County Hospital, Los Angeles, to Inglewood, Los Angeles Co. Hrs. 10-12 and 2-4.

Smith, Arthur M., from Los Angeles Hotel to 340 Douglas Bldg., Los Angeles. Hrs. 10-12 and 2-4. Somers, Howard, from add. unknown to 391 Sutter st., San Francisco. Scroggs, W. R., from Palo Alto, Santa Clara Co., to Westside Hospital, Tuolumne. Hrs. 10-12 and 2-4 and 7-8.

Thomas, Edw. M., from 439 Third st. to 509 -10 Examiner Bldg., San Francisco.

Utley, Jay H., from 939 S. Hope st. to 416 Bradbury Blk., Los Angeles.

New Names.

Brock, L. T., Porter Bldg., San Jose. Med. Dept. Univ. of Oregon, '97. (C) '97. Hrs. 10-12 and 2-5 and 7-8.

Burke, E. W., Palm ave., Highlands. Med. Dept. Univ. Ill., Chicago, '01. (C) '05. Hrs. 8-10 and 2-4.

Bynum, J. C., Ventura. Coll. of P. and S., St. Joseph, Mo., '80. (C) '90. Hrs. 10-12 and 2-4 and 7-9.

Carveth-Higbee, Annie, 1240 S. Union ave., Los Angeles. Trinity Univ., '93. Toronto Univ., '93. Hrs. 1-4 and 7-8.

De Faria, John B., Grant Bldg., San Francisco. Med. and Surg. School of Lisbon, '96. (C) '05. Hrs. 10-12.

Martin, L. A., San Pablo. Coll. of P. & S., San Francisco. Hrs. 1-3 and 7-8.

Mead, Louis, Byron Springs. Coll. of P. and S., New York City, '02. (C) '05. Hrs. 9:30-11 and 1:30-3.

Reed, W. Boardman, cor. Sixth and Figueroa sts., Los Angeles. Med. Dept. Univ. of Penn., '78. (C) '99.

New Members.

Butte County—Gatchell, W. L. F.
Contra Costa County—Dewitt, J. W.; Martin, L. A.; Mead, L. R.

Los Angeles County—Bacon, Chas. E.; Bock, Chas.; Brown, Geo. C.; Chapin, A. R.; Moore, Edw. C.; Porter, C. S.; Putnam, H. A.; Sherry, Henry; Wheeler, L. N.; Wood, Frank L.

San Bernardino County—Andrews, H. F.; Burke, E. W.

San Francisco County—Newton, John C.; Somers, Howard; Whitman, C. H.

San Joaquin County—Blackmun, E. L.; Thompson, G. J.; Young, Jas. A.

San Mateo County—Barret, Walter M.; Morrison, Norman D.; Ross, Jas. L.

Santa Clara County—Avery, Caroline L.; Brock, L. T.; Greenwood, Edna M.; Keith, Wm. E.; Kelley, E. A.; Lyon, S. B.; McMahon, John; Silvia, Clara A.; Ulrich, Edw. J.; Wayland, Chas. A.

Sonoma County—Kimball, M. V.
Ventura County—Bynum, J. C.

Yuba-Sutter County—Bissell, Nelson C.

Deaths.

Bayley, Chas W., Oakdale.
Boynton, C. E., Redding.
Harris, Stephen M., Grass Valley.
Reid, Hiram A., Pasadena.
Risdon, Caroline A., Oakland.
Selfridge, J. M., Oakland.

Convictions in Los Angeles.

Apparently the physicians in Los Angeles did not like to have their city pointed out as the "Mecca of the quack," for they have taken steps to make this gentleman less comfortable than he has been wont to be for a long time past. Since the committee of the County Association took hold of the work, now but a few months ago, 13 arrests have been made, and of the number 6 have been tried, resulting in a conviction in each case. Mrs. S. J. Bridge, fined; E. A. Clark, fined; Wm. Lair, fined; H. C. Tripp, sent to jail; "Prof." M. Guilford, fined; "Dr." Manzeta, fined. Not a single case has thus far been lost, and we sincerely hope that they may have the good fortune not to lose one. Los Angeles, and the committee of the County Association, are to be highly congratulated upon this excellent showing. Keep up the good work, gentlemen, and get rid of all the quacks.